

Group Number: Z1408A
 Plan ID: CCIS5
 Effective Date: August 1, 2008



City County Insurance Services
 Summary of Benefits

BENEFIT	CO-PAYMENT
Annual Maximum	No Annual Maximum
Deductible	No Deductible
Office Visit	\$10 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered at 100%
All X-rays	Covered at 100%
Teeth Cleaning	Covered at 100%
Fluoride Treatment	Covered at 100%
Sealants	Covered at 100%
Head and Neck Cancer Screening	Covered at 100%
Oral Hygiene Instruction	Covered at 100%
Periodontal Charting	Covered at 100%
Periodontal Evaluation	Covered at 100%
RESTORATIVE DENTISTRY AND PROSTHETICS	
Fillings	Covered at 100%
Permanent Crowns	Covered at 100%
Complete Upper or Lower Denture	Covered at 100%
Bridge (Per Tooth)	Covered at 100%
Dental Lab Fees	Covered at 100%
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	Covered at 100%
Root Canal Therapy – Bicuspid	Covered at 100%
Root Canal Therapy – Molar	Covered at 100%
Osseous Surgery (Per Quadrant)	Covered at 100%
Root Planing (Per Quadrant)	Covered at 100%
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered at 100%
Surgical Extraction	\$50
ORTHODONTIA	
Pre-Orthodontic Service	\$150*
Comprehensive Orthodontia	\$1,500
MISCELLANEOUS	
Local Anesthesia (Novocain)	Covered at 100%
Nitrous Oxide	\$10 per Visit
After Hours Emergency Care	\$10
Missed Appointment Fee	\$10
Out of Area Emergency Care Reimbursement Up to \$100	

*Fee credited towards comprehensive orthodontic co-payment if patient accepts treatment plan.

Willamette Dental Insurance, Inc.

This is a summary of your benefits. Please refer to your Certificate of Coverage for a complete description. You may obtain a copy of your Certificate of Coverage from your Employer or Group Representative. In the event of a discrepancy between this summary of benefits and your Certificate of Coverage, the Certificate of Coverage will prevail. For further information regarding Willamette Dental, please visit their website at www.WillametteDental.com.

Exclusions

The Following Services and Supplies Are Not Covered:

- Conscious sedation/general anesthesia.
- Any condition resulting from military service or declared or undeclared war.
- Any injuries sustained while practicing for or competing in a professional or semiprofessional athletic contest. Semiprofessional athletics means an athletic activity for gain or pay that requires an unusually high level of skill and substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.
- Bleaching of a tooth.
- Cast dowel posts.
- Endodontics, bridges, crowns or other service or prosthetic devices requiring multiple treatment dates or fittings if treatment was started or ordered prior to the Member's or Dependent's effective date under the Contract or if the item was installed or delivered more than sixty (60) days after the Member's or Dependent's coverage under the Contract has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within sixty (60) days after termination.
- Charges for endodontic and prosthetic services or supplies provided before the effective date of the Member's or Dependent's coverage that are defective and were not provided according to the dental practice standard of care.
- Charges by any person other than a licensed dentist, licensed denturist, or licensed hygienist.
- Charges that would have been made or that the Member or Dependent would have had no obligation to pay in the absence of coverage under the Contract.
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements.
- Full-mouth reconstruction.
- Orthognathic surgery.
- Cosmetic dentistry or surgery (not including orthodontia).
- Habit breaking or stress-breaking appliances.
- Dental implants or implant supported prosthetics.
- Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst, or nonodontogenic.
- Dental services started prior to the date the person became eligible for services under the Contract.
- Services or supplies provided to correct congenital or developmental malformations including; but not limited to; cleft palate; maxillary and/or mandibular (upper and lower jaw) malformations; enamel hypoplasia; ectodental dysplasia; and fluorosis (discoloration of teeth).
- Services for temporomandibular joint disorders.
- Extraction of permanent teeth for tooth guidance procedures; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures or other orthodontic treatment, unless specifically provided in a rider under the Contract.
- Investigational services or supplies.
- Materials not approved by the American Dental Association.
- Occupational injury or disease (including any arising out of self-employment).
- Personalized restoration, precision attachments, and special techniques.
- Prescription drugs, medications, or supplies.
- Repair or replacement of lost, stolen, or broken items.
- Replacements of an existing denture, crown, or bridge less than five (5) years after the date of the most recent placement.
- Replacement of sound restorations.
- Veneers; composite surfaces on posterior teeth.
- Services or supplies that are not listed as covered under the Contract.
- Services to the extent that they are not necessary for treatment of a dental injury or disease or are not recommended and approved by the licensed dentist attending the Member or Dependent.
- To the extent that coverage is available under any federal, state, or other governmental program if application is duly made, therefore, except where required by law such as cases of emergency or for coverage provided by Medicaid.
- Intentionally self-inflicted injuries. The fact that a person may be under the influence of any chemical substance shall not be considered as a limitation on the ability to form the intent specified in this Section.
- Occlusal guards.
- Services for accidental injury to natural teeth that are provided more than twelve (12) months after the date of the accident.
- Splints, nightguards, and other appliances used to increase vertical dimension and restore bite.
- Hospital or other facility care for dental procedures, including physician services for hospital treatment. However, subject to the hospital co-pay as shown in your Certificate Of Coverage, services of a Licensed Dentist will be provided in a hospital or other facility only when both the following requirements are met:
 - A hospital setting must be medically necessary.
 - The services must be authorized, in writing, in advance by a Participating Dentist.