Certificate of Coverage

Public Employees' Benefit Board
Effective: January 1, 2018

Form No. 002-OR90(1/18)
Agreement No. 4500
Underwritten by Willamette Dental Insurance, Inc.
Welcome to Willamette Dental Group!

Willamette Dental Group would like to welcome you.

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

Contact Information

Appointments or Emergencies
Toll Free ...... 1.855.4DENTAL (433-6825)

Member Services
Monday - Friday ............................. 8 AM to 5 PM PST
Toll Free ............................1.855.4DENTAL (433-6825)
E-mail ... memberservices@willamettedental.com
Website ............. www.WillametteDental.com/PEBB

Visit our website for the most up-to-date locations and doctor profiles, complete with photos, to help you find the best office and provider for you and your family.
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This Certificate of Coverage ("Certificate"), including any amendments, appendices, endorsements, notices, and riders, summarizes the essential features of the 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 Benefits and other provisions of the Contract, please refer to the Contract on file with the Group. If any information in this Certificate is inconsistent with the provisions of the Contract, the Contract shall control.

**Willamette Dental Insurance, Inc.**

6950 NE Campus Way

Hillsboro, Oregon 97124
DEFINITIONS

The following defined terms are used throughout this Certificate.

“Benefit” means a dental service that is covered under the Contract, subject to the terms, conditions, limitations, and exclusions set forth in this Certificate.

“Company” means Willamette Dental Insurance, Inc.

“Contract” means the agreement between the Company and the Group.

“Copayment” means the dollar amount Enrollees must pay for Benefits.

“Dental Emergency” means an acute infection, traumatic damage to the oral cavity, or discomfort that cannot be controlled by non-prescription pain medication.

“Dentist” means a licensed doctor of dental surgery or a licensed doctor of medical dentistry, licensed in the state where treatment is provided.

“Denturist” means a person licensed to practice denture technology licensed in the state where treatment is provided.

“Dependent” means an eligible spouse, domestic partner, or child, who is eligible and enrolled for coverage.

“Enrollee” means any Member or Dependent.

“Group” means the Public Employees’ Benefit Board.

“Member” means an eligible employee of the Group, who is enrolled for coverage.

“Non-Participating Provider” means a Dentist or Denturist that is not a Participating Provider.

“Participating Provider” means Willamette Dental Group, P.C., and the Dentists and Denturists who are employees of Willamette Dental Group, P.C. The Company engages the Participating Provider to provide dental services to Enrollees under the terms of the Contract.

“Premiums” means the amount, including any Member contributions, which the Group must pay to the Company for coverage of each Enrollee.

“Reasonable Cash Value” means the Participating Provider’s usual, and customary fee-for-service price of services.

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

ELIGIBILITY

Member and Dependent Eligibility. To be eligible for coverage under the Contract, the Member and Dependent must be eligible and remain eligible under the Oregon Administrative Rules, Chapter 101 (Public Employees’ Benefit Board (PEBB)). All rules pertaining to enrolling for coverage and when coverage begins will also be in accordance with Oregon Administrative Rules, Chapter 101 (Public Employees’ Benefit Board). The Benefits listed in this Certificate are not subject to a pre-existing condition waiting period.
DENTAL COVERAGE

Agreement to Provide Benefits. The Company agrees to provide Benefits for prescribed services listed in this Certificate as covered, subject to the limitations and exclusions. Services must be provided by a Participating Provider to receive Benefits, unless specified otherwise. The Participating Provider agrees it will accept the amounts established by the Company and the Copayments specified in the appendices as full payment for the covered services provided. All Benefits are expressly subject to the Copayments stated in the appendices and to all other provisions of the Contract.

Referral to a Specialist. If a Participating Provider cannot provide a covered service, the Participating Provider may refer an Enrollee to a Specialist or Non-Participating Provider. Benefits will be provided for services provided by a Specialist or Non-Participating Provider only if all of the following conditions are met:

- The Participating Provider refers the Enrollee;
- The services are authorized by the referral; and
- The services are listed as covered in the appendices.

Office Visit Copayment. The Enrollee is responsible for payment of an office visit Copayment for each visit to a Participating Provider, Specialist, or authorized referral Non-Participating Provider. Office visit Copayments are payable at each visit.

Service Copayment. Some services may require a service Copayment. Service Copayments are payable at the time of service.

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

Rights Not Transferable. Benefits are offered personally to the Enrollee and are not transferable.

EXCLUSIONS & LIMITATIONS

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 Dentist.

- 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.
- The completion or delivery of treatments, or services initiated prior to the effective date of coverage under the Contract, including the following:
  1. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Contract; or
  2. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under the Contract.
- Endodontic services, prosthetic services, and implants that are defective, were not provided in accordance with the professional standard of care, or were provided prior to the effective date of coverage under the Contract. Such services are the liability of the Enrollee, prior dental insurance carrier, and/or Dentist.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service not listed as covered in Appendix A – Schedule of Covered Services and Copayments.
- Experimental or investigational services and related exams or consultations. In determining whether services are experimental or investigational, the Company will consider the following:
  1. Whether the services are in general use in the dental community in the State of Oregon;
  2. Whether the services are under continued scientific testing and research;
  3. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
  4. Whether the services are proven safe and efficacious.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia, deep sedation, or moderate sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by the Participating Provider attending to the Enrollee.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a Dentist, Denturist, hygienist, or dental assistant within the scope of his or her license.
- Services for treatment of injuries sustained while practicing for or competing in a professional or semiprofessional paid athletic contest of any kind.
- Services for treatment of intentionally self-inflicted injuries.
- Services for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers’ compensation or similar law.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons.
- Services that are not listed as covered in Appendix A – Schedule of Covered Services and Copayments.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations.
- **Athletic Mouthguard Replacements.** The replacement of an athletic mouthguard is limited to once every 12 months.
- **Alternative Services.** If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. 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.
- **Congenital Malformations.** Services listed in Appendix A – Schedule of Covered Services and Copayments, which are provided to correct congenital or developmental malformations of the teeth and supporting structure, will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- **Endodontic Retreatment.**
  1. When the initial root canal therapy was performed by a Participating Provider, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After the first 24 months, the applicable Copayments will apply.
  2. When the initial root canal therapy was performed by a Non-Participating Provider, the retreatment of such root canal therapy by a Participating Provider will be subject to the applicable Copayments.
- **Hospital Setting.** The services provided by a Dentist in a hospital setting are covered if the following criteria are met:
  1. A hospital or similar setting is medically necessary.
  2. The services are authorized in writing by a Participating Provider.
  3. The services provided are the same services that would be provided in a dental office.
  4. The hospital call Copayment and other applicable Copayments are paid.
- **Occlusal Guard Replacements.** The replacement of a lost occlusal guard is covered only once in a 2-year period. Repair or replacement of a broken or damaged occlusal guard is covered as needed.
• **Replacements.** The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is dentally necessary due to one of the following conditions:
  1. A tooth within an existing denture or bridge is extracted;
  2. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
  3. 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.

• **Restorations.** Crown, cast, or other indirect fabricated restorations are covered only if dentally necessary or if recommended by the Participating Provider. A crown, cast, or other indirect fabricated restoration is considered dentally necessary if treatment is 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.

**TERMINATION OF COVERAGE**

**Termination of Coverage.** Coverage shall terminate on the earliest of the following:

- On the date of termination of the Contract.
- On the last day of the month for which Premiums are paid, if the Premiums are not received by the due date or within the grace period as specified in the Contract.
- On the last day of the month during which eligibility ceases.
- On the last day of the month, following at least 30 days’ advance written notice 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 a Participating Provider, physical or verbal abuse towards a Participating Provider, office staff, or other patients, or non-payment of Copayments.
- If coverage terminates for a Member, it will terminate for Dependents, except in certain circumstances when the Dependent is eligible to continue coverage in accordance with the Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board).

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

**Cessation of Benefits.** No person shall have or acquire a vested right to receive Benefits after termination of the Contract. Termination of the Contract completely ends all obligations of the Company to provide Benefits, even if the Enrollee was receiving treatment while the Contract was in force or needs treatment for any existing condition, unless specified otherwise.

**Continuation Rights.** Coverage may be continued in certain circumstances in accordance with the Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board). The Group agrees to notify all Enrollees of their right to continuation of coverage and administer continuation of coverage in accordance with state and federal laws. For further details, Enrollees should refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

- **Spouse Continuation Coverage.** A legally separated, divorced, or surviving spouse age 55 or over may elect to continue coverage, in accordance with Oregon law. Eligible children of the spouse may remain covered. For complete information regarding rights under the Spouse Continuation Coverage, please contact the Group.

- **State-Mandated Continuation Coverage.** Coverage may continue in accordance with any state-mandated leave act or law. For complete information regarding rights under the state-mandated continuation of coverage, please contact the Group.

- **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 Group is responsible for administering COBRA continuation coverage. For complete information regarding rights under COBRA, please contact the Group.
If the Enrollee is eligible for continuation rights and elects to continue coverage, the Enrollee must submit timely payment of Premiums through the Group.

Reinstatement. If coverage terminates because a Member ceases to be eligible, reinstatement may be available in accordance with Oregon Administrative Rules, Chapter 101 (Public Employees’ Benefit Board).

Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Anyone terminated for good cause or failure to make timely payment of Copayments is not eligible for an extension of Benefits.

- **Crowns or Bridges.** Adjustments for crowns or bridges will be covered for up to 6 months after placement if the final impressions are taken prior to termination of coverage and the crown or bridge is placed within 60 days of termination.
- **Removable Prosthetic Devices.** Adjustments for removable prosthetic devices will be covered for up to 6 months after placement if final impressions are taken prior to termination of coverage and the removable prosthetic device is delivered within 60 days after termination. Laboratory relines are not covered after termination.
- **Immediate Dentures.** Benefits for dentures may be extended if final impressions are taken prior to termination or coverage 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.
- **Root Canal Therapy.** Benefits for root canal therapy will be extended if the root canal is started prior to termination of coverage and treatment is completed within 60 days after termination. Pulpal debridement is not a root canal start. If after 60 days from termination of coverage the root canal requires re-treatment, re-treatment will not be covered. Restorative work following root canal therapy is a separate procedure and not covered after termination.
- **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.

**GENERAL PROVISIONS**

**Emergency Care.**

- 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. Generally, Enrollees can be seen by a Participating Provider for a Dental Emergency within approximately 24 hours.
- If Participating Providers’ offices are closed, an 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.
- The Enrollee may seek treatment from any Dentist for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Participating Provider office. The Enrollee may seek reimbursement for the cost of the covered services provided up to the Out of Area Emergency Reimbursement amount less any Copayment amounts specified in Appendix A – Schedule of Covered Services and Copayments. A written request for reimbursement must be submitted to the Company within 6 months of the date of service. The written request should include the Enrollee’s signature, the attending Dentist’s signature, and the attending Dentist’s itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The Out of Area Emergency Reimbursement will not be provided if the requested information is not received.

**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.
**Definitions**

a. A Plan is any of the following that provides benefits or services for medical or dental care or treatment.
   If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
   1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
   2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

b. This Plan means, in this COB provision, the part of the contract providing 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.

- **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 other than as 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 dependent 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 Paragraph 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 the rule labeled d(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the primary plan and the Plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the primary plan.

- **Effect on the Benefits of This Plan.**
  a. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Covered Service, the secondary plan will calculate the benefits it would have paid in the absence of other dental 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.

- **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.

- **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.
• **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.

**Subrogation.** Benefits may be available for an injury or disease, which is allegedly the liability of a third party. Such services provided by the Participating Provider are solely to assist the Enrollee. By incurring the Reasonable Cash Value of the Benefits provided in the form of services, the Participating Provider is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

- If the Participating Provider provides services for the treatment of an injury or disease, which is allegedly the liability of a third party, it shall:
  1. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Benefits provided in the form of services; and
  2. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Benefits provided in the form of services, subject to the limitations specified in below.
- As a condition of receiving Benefits, the Enrollee shall:
  1. Provide the Participating Provider with the name and address of the parties liable, all facts known concerning the injury, and other information as reasonably requested;
  2. Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Participating Provider’s subrogation rights; and
  3. Take all necessary action to seek and obtain recovery to reimburse the Participating Provider.
- The Participating Provider shall be reimbursed with any amounts received from the third party or third party’s insurer(s). The amount shall not exceed the Reasonable Cash Value of the services provided for treatment of the injury or disease.
- The Contract does not provide Benefits for services payable under any motor vehicle medical, motor vehicle no-fault, underinsured or uninsured motorist, personal injury protection, homeowner’s, commercial premises coverage, workers’ compensation, or other similar contract or insurance.
- The refusal or failure, without good cause, to cooperate with the Company or Participating Provider are grounds for recovery by the Participating Provider from the Enrollee for the Reasonable Cash Value of the Benefits provided in the form of services.

**Complaints, Grievances, and Appeals Procedures.**

- **Complaints.**
  1. 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.
  2. 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.
  3. 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)
  4. If the Enrollee remains unsatisfied after discussing with the Participating Provider, office staff or the Member Services Department, grievance and appeal procedures are available for complaints pertaining to a denied Benefit or service.
- **Grievances.**
  1. A grievance is a written complaint expressing dissatisfaction with the denial of a requested Benefit or service. The Enrollee should outline his or 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.
  2. The Company will review the grievance and all information submitted. The Company will provide a written reply within 30 days of the Company’s receipt of the grievance. 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 Benefit request involves:
A preauthorization, the Company will provide a written reply within 15 days of the Company's receipt of the grievance.

Services deemed experimental or investigational, the Company will provide a written reply within 20 working days of the Company's receipt of the grievance.

Services not yet provided for an alleged Dental Emergency, the Company will provide a reply within 72 hours of the Company's receipt of the grievance.

3. If the grievance is denied, the written reply will include information about the basis for the decision; how to appeal; and other disclosures as required under state and federal laws.

Appeals.

1. An appeal is the process for requesting reconsideration of a denied grievance. An appeal request must be submitted, in writing, to the Member Services Department within 180 days of the date on the written reply to the grievance. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information.

2. The Company will review the appeal and all information submitted. The person conducting the appeal review will be someone other than the person who denied the claim, and will not be subordinate to that person. The Company will provide a written reply within 60 days of the Company's receipt of the appeal. If the appeal involves:

   - A preauthorization, the Company will provide a written reply within 30 days of the Company's receipt of the appeal.
   - Services deemed experimental or investigational, the Company will provide a written reply within 20 working days of the Company's receipt of the appeal.
   - Services not yet provided for an alleged Dental Emergency, the Company will provide a reply within 72 hours of the Company's receipt of the appeal.

3. 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.

Note: The Enrollee also has the right to file a dental coverage complaint with the Oregon Division of Financial Regulation at the following address:

   Consumer Advocacy Unit, Oregon Division of Financial Regulation
   P.O. Box 14480, Salem, OR 97309-0405
   Website: insurance.oregon.gov or E-mail: cp.ins@oregon.gov
   (503) 947-7984 or (888) 877-4894 (toll-free)

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.

Severability. If any provision of the Contract is deemed invalid or illegal, that provision shall be fully severable and the remaining provisions of the Contract shall continue in full force and effect.

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.

Statements. All statements made by applicants, the Group, 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 Group or the insured person.
## APPENDIX A – SCHEDULE OF COVERED SERVICES AND COPAYMENTS

1. **Office Visit**
   - General Office Visit: $5
   - Specialist Office Visit: $5

2. **Diagnostic and Preventive Services**
   - **D0120** Periodic oral evaluation - established patient: None
   - **D0140** Limited oral evaluation - problem focused: None
   - **D0145** Oral evaluation for patient under 3 years of age and counseling with primary caregiver: None
   - **D0150** Comprehensive oral evaluation - new or established patient: None
   - **D0160** Detailed & extensive oral evaluation - problem focused, by report: None
   - **D0170** Re-evaluation - limited, problem focused (established patient; not post-operative visit): None
   - **D0180** Comprehensive periodontal evaluation - new or established patient: None
   - **D0210** Intraoral - complete series of radiographic images: None
   - **D0220** Intraoral - periapical 1st radiographic image: None
   - **D0230** Intraoral - periapical each additional radiographic image: None
   - **D0240** Intraoral - occlusal radiographic image: None
   - **D0250** Extra-oral - 2D projection radiographic image: None
   - **D0270** Bitewing - single radiographic image: None
   - **D0272** Bitewings - 2 radiographic images: None
   - **D0273** Bitewings - 3 radiographic images: None
   - **D0274** Bitewings - 4 radiographic images: None
   - **D0277** Vertical bitewings - 7 to 8 radiographic images: None
   - **D0330** Panoramic radiographic image: None
   - **D0340** Cephalometric radiographic image: None
   - **D0350** 2D oral/facial photographic image obtained intraorally or extraorally: None
   - **D0425** Caries susceptibility tests: None
   - **D0460** Pulp vitality tests: None
   - **D0470** Diagnostic casts: None
   - **D1110** Prophylaxis - adult: None
   - **D1120** Prophylaxis - child: None
   - **D1206** Topical application of fluoride varnish: None
   - **D1208** Topical application of fluoride – excluding varnish: None
   - **D1310** Nutritional counseling for control of dental disease: None
   - **D1320** Tobacco counseling for the control and prevention of oral disease: None
   - **D1330** Oral hygiene instructions: None
   - **D1351** Sealant - per tooth: None

3. **Space Maintainers**
   - **D1510** Space maintainer - fixed - unilateral: None
   - **D1515** Space maintainer - fixed - bilateral: None
   - **D1520** Space maintainer - removable - unilateral: None
   - **D1525** Space maintainer - removable - bilateral: None
   - **D1550** Re-cement or re-bond space maintainer: None
   - **D1555** Removal of fixed space maintainer: None

4. **Restorative Dentistry**
   - **D2140** Amalgam - 1 surface, primary or permanent: None
   - **D2150** Amalgam - 2 surfaces, primary or permanent: None
   - **D2160** Amalgam - 3 surfaces, primary or permanent: None
   - **D2161** Amalgam - 4 or more surfaces, primary or permanent: None
   - **D2330** Resin-based composite - 1 surface, anterior: None
   - **D2331** Resin-based composite - 2 surfaces, anterior: None
   - **D2332** Resin-based composite - 3 surfaces, anterior: None
   - **D2335** Resin-based composite - 4 or more surfaces or involving incisal angle (anterior): None
   - **D2390** Resin-based composite crown, anterior: None
D2391 Resin-based composite - 1 surface, posterior
D2392 Resin-based composite - 2 surfaces, posterior
D2393 Resin-based composite - 3 surfaces, posterior
D2394 Resin-based composite - 4 or more surfaces, posterior

D2510 Inlay - metallic - 1 surface $190
D2520 Inlay - metallic - 2 surfaces $190
D2530 Inlay - metallic - 3 or more surfaces $190
D2542 Onlay - metallic - 2 surfaces $190
D2543 Onlay - metallic - 3 surfaces $190
D2544 Onlay - metallic - 4 or more surfaces $190

D2610 Inlay - porcelain/ceramic - 1 surface $190
D2620 Inlay - porcelain/ceramic - 2 surfaces $190
D2630 Inlay - porcelain/ceramic - 3 or more surfaces $190
D2642 Onlay - porcelain/ceramic - 2 surfaces $190
D2643 Onlay - porcelain/ceramic - 3 surfaces $190
D2644 Onlay - porcelain/ceramic - 4 or more surfaces $190

5. Crowns
D2710 Crown - resin-based composite (indirect) $190
D2740 Crown - porcelain/ceramic substrate $190
D2750 Crown - porcelain fused to high noble metal $190
D2782 Crown - ¾ cast noble metal $190
D2792 Crown - full cast noble metal $190
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration None
D2920 Re-cement or re-bond crown None
D2930 Prefabricated stainless steel crown - primary tooth None
D2931 Prefabricated stainless steel crown - permanent tooth None
D2932 Prefabricated resin crown None
D2933 Prefabricated stainless steel crown with resin window None
D2940 Protective restoration None
D2950 Core buildup, including any pins when required None
D2951 Pin retention - per tooth, in addition to restoration None
D2954 Prefabricated post and core in addition to crown None
D2955 Post removal None
D2957 Each additional prefabricated post - same tooth None
D2970 Temporary crown (fractured tooth) None
D2975 Coping None
D2980 Crown repair necessitated by restorative material failure None

6. Endodontics
D3110 Pulp cap - direct (excluding final restoration) None
D3120 Pulp cap - indirect (excluding final restoration) None
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament None
D3221 Pulpal debridement, primary and permanent teeth None
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) None
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) None
D3310 Endodontic therapy, anterior tooth (excluding final restoration) None
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration) None
D3330 Endodontic therapy, molar (excluding final restoration) None
D3331 Treatment of root canal obstruction; non-surgical access None
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth None
D3333 Internal repair of perforation defects None
D3346 Retreatment of previous root canal therapy - anterior None
D3347 Retreatment of previous root canal therapy - bicuspid
D3348 Retreatment of previous root canal therapy - molar
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair or perforations, root resorption, etc.)
D3352 Apexification/recalcification - interim medication replacement
D3353 Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy - anterior
D3421 Apicoectomy - bicuspid (1st root)
D3425 Apicoectomy - molar (1st root)
D3426 Apicoectomy (each additional root)
D3430 Retrograde filling - per root
D3450 Root amputation - per tooth
D3920 Hemisection (including any root removal), not including root canal therapy
D3950 Canal preparation and fitting of a preformed dowel or post

7. Periodontics
D4210 Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant
D4211 Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant
D4240 Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant
D4241 Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening - hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant
D4263 Bone replacement graft - retained natural tooth - first site in quadrant
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft
D4274 Mesial/distal I wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site
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
D4341 Periodontal scaling and root planing - 4 or more teeth per quadrant
D4342 Periodontal scaling and root planing - 1 to 3 teeth per quadrant
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 Periodontal maintenance

8. Prosthodontics - Removable
D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5130 Immediate denture - maxillary
D5140 Immediate denture - mandibular
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>None</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>None</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
<td>None</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
<td>None</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
<td>None</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
<td>None</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>None</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
<td>None</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp – per tooth</td>
<td>None</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>None</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>None</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture – per tooth</td>
<td>None</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
<td>None</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
<td>None</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
<td>None</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
<td>None</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
<td>None</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
<td>None</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>None</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
<td>None</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>None</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
<td>None</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>None</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>None</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>None</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>None</td>
</tr>
<tr>
<td>D5810</td>
<td>Interim complete denture (maxillary)</td>
<td>$95</td>
</tr>
<tr>
<td>D5811</td>
<td>Interim complete denture (mandibular)</td>
<td>$95</td>
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<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary)</td>
<td>$95</td>
</tr>
<tr>
<td>D5821</td>
<td>Interim partial denture (mandibular)</td>
<td>$95</td>
</tr>
<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
<td>None</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
<td>None</td>
</tr>
<tr>
<td>D5863</td>
<td>Overdenture – complete maxillary</td>
<td>$190</td>
</tr>
<tr>
<td>D5864</td>
<td>Overdenture – partial maxillary</td>
<td>$190</td>
</tr>
<tr>
<td>D5865</td>
<td>Overdenture – complete mandibular</td>
<td>$190</td>
</tr>
<tr>
<td>D5866</td>
<td>Overdenture – partial mandibular</td>
<td>$190</td>
</tr>
<tr>
<td>D5986</td>
<td>Fluoride gel carrier</td>
<td>None</td>
</tr>
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</table>

9. **Prosthodontics - Fixed**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic - porcelain fused to predominantly base metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>$190</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown - porcelain fused to high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - ¾ cast high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal</td>
<td>$190</td>
</tr>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>None</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair necessitated by restorative material failure</td>
<td>None</td>
</tr>
</tbody>
</table>

10. **Oral Surgery**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
<td>None</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>None</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>None</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>None</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>None</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>None</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony with unusual surgical complications</td>
<td>None</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Code</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal residual roots (cutting procedure)</td>
<td>None</td>
</tr>
<tr>
<td>D7260</td>
<td>Oroantral fistula closure</td>
<td>None</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>None</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
<td>None</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>None</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant</td>
<td>None</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant</td>
<td>None</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant</td>
<td>None</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant</td>
<td>None</td>
</tr>
<tr>
<td>D7340</td>
<td>Vestibuloplasty - ridge extension (secondary epithelialization)</td>
<td>None</td>
</tr>
<tr>
<td>D7350</td>
<td>Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)</td>
<td>None</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
<td>None</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision &amp; drainage of abscess - intraoral soft tissue</td>
<td>None</td>
</tr>
<tr>
<td>D7520</td>
<td>Incision &amp; drainage of abscess - extraoral soft tissue</td>
<td>None</td>
</tr>
<tr>
<td>D7530</td>
<td>Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue</td>
<td>None</td>
</tr>
<tr>
<td>D7540</td>
<td>Removal of reaction producing foreign bodies, musculoskeletal system</td>
<td>None</td>
</tr>
<tr>
<td>D7550</td>
<td>Partial ostectomy/sequestrectomy for removal of non-vital bone</td>
<td>None</td>
</tr>
<tr>
<td>D7670</td>
<td>Alveolus - closed reduction, may include stabilization of teeth</td>
<td>None</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
<td>None</td>
</tr>
<tr>
<td>D7911</td>
<td>Complicated suture - up to 5 cm</td>
<td>None</td>
</tr>
<tr>
<td>D7953</td>
<td>Bone replacement graft for ridge preservation - per site</td>
<td>None</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another</td>
<td>None</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision hyperplastic tissue - per arch</td>
<td>None</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
<td>None</td>
</tr>
</tbody>
</table>

11. Anesthesia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia</td>
<td>Not covered</td>
</tr>
<tr>
<td>D9230</td>
<td>Inhalation of nitrous oxide/analgnesia, anxiolysis</td>
<td>None</td>
</tr>
</tbody>
</table>

12. Miscellaneous

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain - minor procedure</td>
<td>None</td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>None</td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital call or ambulatory surgical center call</td>
<td>$125</td>
</tr>
<tr>
<td>D9430</td>
<td>Office visit for observation (during regularly scheduled hours) - no other services performed</td>
<td>None</td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit - after regularly scheduled hours</td>
<td>None</td>
</tr>
<tr>
<td>D9910</td>
<td>Application of desensitizing medicament</td>
<td>None</td>
</tr>
<tr>
<td>D9911</td>
<td>Application of desensitizing resin for cervical and/or root surface, per tooth</td>
<td>None</td>
</tr>
<tr>
<td>D9940</td>
<td>Occlusal guard, by report</td>
<td>None</td>
</tr>
<tr>
<td>D9941</td>
<td>Fabrication of athletic mouthguard</td>
<td>$100</td>
</tr>
<tr>
<td>D9942</td>
<td>Repair and/or reline of occlusal guard</td>
<td>None</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment - limited</td>
<td>None</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment - complete</td>
<td>None</td>
</tr>
<tr>
<td>D9970</td>
<td>Enamel microabrasion</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Out-of-service area emergency reimbursement</td>
<td>Enrollee is reimbursed up to $150</td>
</tr>
</tbody>
</table>
APPENDIX B – ORTHODONTIC TREATMENT

- **General Provisions.**
  1. Benefits for orthodontic treatment are provided only if the Participating Provider prepares the treatment plan prior to starting orthodontic treatment. The treatment plan is based on an examination that must take place while the Enrollee is covered under the Contract. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.
  2. 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.
  3. For orthodontic treatment started prior to the effective date of coverage, Copayments may be adjusted based upon the services necessary to complete the treatment.
  4. If Benefits for orthodontic services terminate prior to completion of orthodontic treatment, Benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the Copayment may be prorated. The services necessary to complete treatment will be billed at the Reasonable Cash Value.
  5. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services provided. The Pre-Orthodontic Service Copayments will be deducted from the Comprehensive Orthodontic Service Copayment if the Enrollee accepts the treatment plan.
  6. The General Office Visit Copayment listed in Appendix A – Schedule of Covered Services and Copayments is charged at each visit for orthodontic treatment. Services connected with orthodontic treatment are subject to the Copayments listed in Appendix A – Schedule of Covered Services and Copayments. All Copayments must be paid in full at the time of service.

- **Pre-Orthodontic Service Copayments.**
  - Initial orthodontic exam: $25
  - Study models and X-rays: $125
  - Case presentation: $0

- **Orthodontic Service Copayment.** The Orthodontic Service Copayment must be paid in full prior to commencement of orthodontic treatment.
  - Comprehensive Orthodontic Service Copayment: $1,500 per case

The following procedures are provided under the Benefits for orthodontic services:
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition
- D8040 Limited orthodontic treatment of the adult dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition
- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8090 Comprehensive orthodontic treatment of the adult dentition
APPENDIX C – IMPLANT SERVICES

- The Benefits for implant services will be provided when the treatment plan is prepared by a Participating Provider prior to receiving implant services. The treatment plan is based on an examination that must take place while the Enrollee is covered. Benefits for implant services will be provided only if approved by a Participating Provider and if the entire implant procedure, including surgery and application of prosthetic, occurs while the Enrollee is covered.

- If coverage under the Contract terminates prior to completion of implant treatment (including application of prosthetic), there may be additional charges for implant services provided after termination. If Benefits for implant services terminate before the end of the prescribed treatment period, Benefits will continue through the end of the month in which the Benefits for implant services are terminated. Implant treatment provided after coverage under the Contract has terminated, including application of prosthetic(s) will be prorated based on the Reasonable Cash Value of the service.

- **Implant Service Copayments.** Services provided in connection with implant treatment are subject to the Copayments listed below and the applicable Copayments listed in Appendix A - Schedule of Covered Services and Copayments. All Copayments must be paid in full at the time of service. In addition, only the implant services listed below will be covered under the Implant Services Benefit. All other implant services will be subject to Copayments, including any office visit Copayments, as stated in Appendix A - Schedule of Covered Services and Copayments or will not be covered.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6010</td>
<td>Surgical placement of implant body: endosteal implant</td>
<td>$1,720</td>
</tr>
<tr>
<td>D6053</td>
<td>Implant/abutment supported removable denture for completely edentulous arch</td>
<td>$1,235</td>
</tr>
<tr>
<td>D6054</td>
<td>Implant/abutment supported removable denture for partially edentulous arch</td>
<td>$1,235</td>
</tr>
<tr>
<td>D6055</td>
<td>Connecting bar – implant supported or abutment supported</td>
<td>None</td>
</tr>
<tr>
<td>D6056</td>
<td>Prefabricated abutment – includes modification and placement</td>
<td>None</td>
</tr>
<tr>
<td>D6057</td>
<td>Custom fabricated abutment – includes placement</td>
<td>None</td>
</tr>
<tr>
<td>D6059</td>
<td>Abutment supported porcelain fused to metal crown (high noble metal)</td>
<td>$1,025*</td>
</tr>
<tr>
<td>D6062</td>
<td>Abutment supported cast metal crown (high noble metal)</td>
<td>$1,025*</td>
</tr>
<tr>
<td>D6069</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)</td>
<td>$810</td>
</tr>
<tr>
<td>D6072</td>
<td>Abutment supported retainer for cast metal FPD (high noble metal)</td>
<td>$810</td>
</tr>
<tr>
<td>D6080</td>
<td>Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments</td>
<td>None</td>
</tr>
<tr>
<td>D6090</td>
<td>Repair implant supported prosthesis, by report</td>
<td>None</td>
</tr>
<tr>
<td>D6095</td>
<td>Repair implant abutment, by report</td>
<td>None</td>
</tr>
<tr>
<td>D6190</td>
<td>Radiographic/surgical implant index, by report</td>
<td>None</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
<td>$190</td>
</tr>
</tbody>
</table>

* **Two Teeth Implant:** The total amount of Implant Service Copayments incurred by an Enrollee for procedures associated with a two teeth implant delivered on the same date of service shall not exceed $5,060 under the Implant Services Benefit. This amount shall not include additional fees incurred by the Enrollee for services not covered under the Implant Services Benefit.

**Three Teeth Implant:** The total amount of Implant Service Copayments incurred by an Enrollee for procedures associated with a three teeth implant delivered on the same date of service shall not exceed $7,210 under the Implant Services Benefit. This amount shall not include additional fees incurred by the Enrollee for services not covered under the Implant Services Benefit.
Public Employees’ Benefit Board

Willamette Dental Insurance, Inc.
Certificate of Coverage