Willamette™
Dental Group

"You're telling me my teeth can really last a lifetime?"

First In Proactive Dental Care

OREGON EDUCATORS OEBB BENEFIT BOARD

Willamette Dental Group
Plan 8
Certificate of Coverage

Oregon Educators Benefit Board
Effective: October 1, 2012

Willamette Dental Insurance, Inc.
Form No. OEBB2012COC

Welcome to Willamette Dental Group!

Willamette Dental Group would like to welcome you to Dental Plan 8.

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

Contact Information:

Appointments or Emergencies

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

Member Services

Monday - Friday .....8 AM to 5 PM PST
Toll Free ..... 1.855.4DENTAL (433-6825), Option 3
E-mail .... memberservices@willamettedental.com
Website .....www.WillametteDental.com/OEBB

54 Convenient Office Locations

Oregon Locations

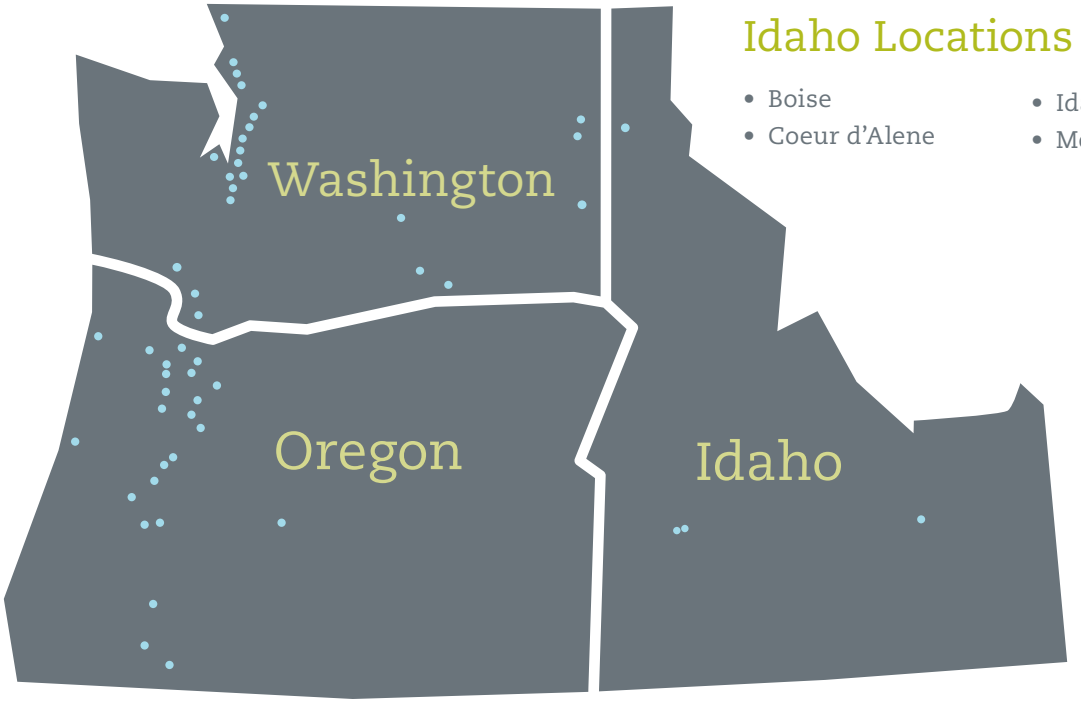
- Albany
- Beaverton
- Beaverton Specialty
- Bend
- Corvallis
- Downtown Portland
- Eastport
- Eugene
- Gateway Specialty
- Grants Pass
- Gresham
- Hillsboro
- Lincoln City
- Medford
- Milwaukie
- Roseburg
- Salem – Lancaster
- Salem – Liberty
- S.E. Stark
- Stark Specialty
- Springfield
- Tigard
- Tillamook
- Tualatin
- Weidler

Washington Locations

- Bellevue
- Bellingham
- Everett
- Federal Way
- Kennewick
- Kent
- Lakewood
- Longview
- Lynnwood
- Northgate
- Northgate Specialty
- Renton
- Richland
- Seattle
- Silverdale
- Spokane – Northpointe
- Spokane – South Hill
- Tacoma
- Tumwater
- Vancouver – Hazel Dell
- Vancouver – Mill Plain
- Yakima

Idaho Locations

- Boise
- Coeur d'Alene
- Idaho Falls
- Meridian



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This Certificate of Coverage ("Certificate"), including any amendments, appendices, endorsements, notices and riders, summarizes the essential features of the Contract. This Certificate replaces and supersedes all prior Certificates. For complete details on Benefits and other provisions of the Contract, please refer to the Contract on file with the Policyholder. If any information in this Certificate is inconsistent with the terms and provisions of the Contract, the Contract shall control.

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

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

PLAN INTRODUCTION

We are pleased to offer you, as an OEBB member, a high value dental insurance plan designed with the best health of you and your family in mind. We offer a unique system that not only offers you value-based dental insurance but provides you with quality dental care as well. Professional general practitioners, specialists, hygienists, and quality support staff from Willamette Dental Group, P.C., in Oregon, Washington, and Idaho provide the care for your dental plan. Willamette Dental Group has been providing dental care in the Pacific Northwest for over 40 years and has been providing quality care to educators for over 25 years.

Treatment Philosophy

At Willamette Dental Group, we don't start any treatment without a thorough evaluation and planning process. We don't drill until clinically it's the right thing to do, and we certainly don't wait for problems to arise. The sad truth is that some dentists do. Willamette Dental Group has been the leader in proactive preventive care for over 40 years and we practice dentistry a little differently. We believe a healthy mouth is the foundation of all dental care and, because our focus is health-based rather than disease-based, our proactive method is wholly rooted in prevention. In fact, with your personalized dental plan and with proper care, your teeth can be healthy enough to last the rest of your life.

A key to this philosophy is our emphasis on preserving the patient's natural tooth-structure and preventing dental disease. By using proven techniques, including non-surgical methods of treatment, our practitioners can help to prevent or even reverse dental disease. As a body of dental care professionals, our practice emphasizes providing only the appropriate treatment that will lead to the optimum oral health of our patients.

Key Plan Features

Predictable Costs

There are no deductibles and no annual maximums. A Member simply pays any applicable service copayment and office visit charge at the time of service. These copayments include all lab work.

Responsive, Flexible and Simple Service

There are no claim forms and no pre-authorizations for a Member to fill out. Simply select the Willamette Dental Group office of choice and pay any applicable copayments. We will take care of the rest. Plus, we make scheduling appointments as simple as possible, with a centralized appointment center and our simple schedule approach.

Comprehensive Benefits

Our dentists will work to maintain dental health through routine exams and other preventive services. Preventive services such as cleanings, periodic x-rays, sealants, fillings, and fluoride applications are covered with payment of the office visit charge so that the Member will maintain superior dental health.

Major dental work such as crowns, bridges, and dentures are covered under this Plan with payment of the office visit charge. Orthodontics and dental implants are also covered, with modest service copayments. Orthodontia and dental implants services are subject to an office visit charge which is not included in the service copayment amount.

Quality Assurance

Willamette Dental Group has an extensive Quality Assurance program. Our Quality Assurance staff includes practicing dentists who review and audit charts to ensure the highest quality of service and assure our standards exceed state requirements. Quality Assurance begins with the recruitment of accomplished dentists and staff members. These dentists must meet strict credentialing measures. All dentists, both general and board-certified specialists, are salaried employees of Willamette Dental Group. As employees, the dentists and specialists all practice under the same treatment planning guidelines. Quality coverage, which includes health and safety measures, is extremely important to us. Members can be assured our health protection control and safety measures exceed OSHA, WISHA, and state requirements. These attributes have made Willamette Dental Group one of the largest dental practices in the United States.

Here's How Our Plan Works

As a Willamette Dental Group Plan member, you have a choice of which of our providers and offices is best for you. Each of our more than 740 dental professionals practices today's latest scientific approaches to dental care and they must meet and maintain one of the highest credentialing standards in the dental industry. All routine appointments will be scheduled with the Member's primary dentist, unless otherwise specified at the time the appointment is arranged. There is no need for everyone in your family to visit the same office location or same provider, as each Member may select his or her office location and provider.

Choosing a Provider

The primary care dentist each Member selects will coordinate all the Member's dental care needs. A primary care dentist offers a personal and individual approach to dental treatment by becoming familiar with each Member's dental history. In order to receive benefits under this program, treatment must be rendered by a Willamette Dental Group provider, except in the case of an out-of-service-area emergency dental situation or upon referral by a Willamette Dental Group dentist. Unless a specific Willamette Dental Group dentist is requested, an appointment will be made with the first available dentist at the location of the Member's choice. We believe in continuity of care. In order to establish a good dentist-patient relationship, future appointments will be scheduled with the Member's primary care dentist unless a permanent change is requested.

Simple Scheduling for Appointments

Visiting your Willamette Dental Group dentist is as easy as "Ready, Set, Go!"

Ready…call us when you are ready to be seen.
Set…we will work with your schedule to find an appointment for you.
Go!...receive quality care in fewer office visits, saving you time and money!

To schedule an appointment at the office most conveniently located near you, simply call the Appointment Center at 855.4DENTAL (433-6825).

If you need to reschedule or cancel an appointment, please call the Appointment Center as soon as possible. The office will apply a missed appointment fee to your account for any missed appointment without 24 hours prior notice.

Your First Visit

At your first visit to our office, you will receive a thorough dental examination that includes X-rays and comprehensive risk assessments. Then, your dentist will develop a Personal Dental Care Plan based on your immediate needs, current dental health and long term oral health goals. This individual plan will include recommendations for cleanings, restorations and preventive treatments.

Follow-Up Care

Based on the treatment plan established by the primary care dentist, additional routine appointments will be scheduled at periodic intervals. Some Members require several cleanings; others require a cleaning every nine months or only once each year. The Member's dentist will discuss with the Member what they recommend as a personal treatment plan. If there are questions about the treatment plan, we encourage Members to discuss this directly with the dentist at that time.

Specialty Services

Willamette Dental Group dentists provide a full range of general and specialty dental services. For most treatment, the Member will see their selected primary dentist; however, the dentist may refer the Member for a covered dental service to a Specialist. Services will be covered up to this Plan's specifications for those procedures authorized by the Member's referring Willamette Dental Group dentist. This Plan does not cover specialty services unless the Member is referred by a Willamette Dental Group dentist. If the Member has any questions regarding these services, please contact our Member Services Department at 855.4DENTAL (433-6825).

DEFINITIONS

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

"Active Eligible Employee" means an employee of an Educational Entity who is employed on a half-time or greater basis or meets the definition of an Eligible Employee under an OEBB rule or under a collective bargaining agreement or documented district policy in effect on January 31, 2008.

"Appeal" means a request for further action/resolution after the initial grievance is unresolved on a denial of authorization for a covered service, denial of payment for a claim, or a denial of benefits.

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

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

"Company" means Willamette Dental Insurance, Inc.

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

"Contract" means the agreement between Willamette Dental Insurance, Inc., and OEBB.

"Dental Emergency" means 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.

"Educational Entity" means public school districts (K-12), education service districts (ESDs), community colleges and public charter schools participating in OEBB.

"Eligible Employee" means an Active Eligible Employee or Retired Eligible Employee.

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

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

"Grievance" means a written complaint submitted by or on behalf of a Member expressing dissatisfaction with the denial of a requested Benefit or service.

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

"Member" means a Participating Employee, or a Family Member of a Participating Employee, who is enrolled under this Plan.

"Oregon Educations Benefit Board (OEBB)" means the program created under Chapter 0007, Oregon Laws 2007.

"Participating Dentist" means a Dentist who is employed by or is under contract with Willamette Dental Group, P.C., or any of its affiliates to provide dental services.

"Participating Employee" means an OEBB member who is an Eligible Employee of an Educational Entity and who is covered by this Plan.

"Participating Provider" means Willamette Dental Group, P.C., or any of its affiliated dental practices. The Participating Provider is engaged by the Company to provide dental services under the terms of the Contract.

"Plan" means this OEBB-sponsored dental plan to which the Contract applies.

"Plan Administrator" means OEBB or a person or entity who has been designated by OEBB as its administrative agent. Duties include, but are not limited to, the issuance of monthly eligibility reports, payment of premium and issuance and receipt of notices under the Contract or this Certificate.

"Policyholder" means Oregon Educators Benefit Board (OEBB).

"Premium" means the total dollar amount to be paid to the Company each month in consideration of the Benefits.

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

"Retired Eligible Employee" means a previously Active Eligible Employee, who meets the definition of a Retired Eligible Employee under an OEBB rule or under a collective bargaining agreement or documented district policy in effect on January 31, 2008.

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

ELIGIBILITY

Eligibility for OEBB benefits is based on rules in Oregon Administrative Rules (OAR) as amended. OEBB eligibility rules are codified in Chapter 111-015 OAR, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at http://oregon.gov/OHA/OEBB/administrativerules.shtml.

ENROLLMENT

OEBB's enrollment rules are codified in Chapter 111-040 OAR, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at http://oregon.gov/OHA/OEBB/administrativerules.shtml.

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

EFFECTIVE DATE OF COVERAGE

OEBB's rules for the effective date of coverage are codified in Chapter 111-040 OAR, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at http://oregon.gov/OHA/OEBB/administrativerules.shtml.

TERMINATION OF COVERAGE

OEBB's rules for the termination of coverage are codified in Chapter 111-040 OAR, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at http://oregon.gov/OHA/OEBB/administrativerules.shtml.

Termination for Just Cause

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

a. Abuses or threatens the safety of Company personnel or of any person or property of the Participating Provider;
b. Fails to comply with the provisions of this Plan, which shall include, but is not limited to:
    (1) An inability to establish or maintain a satisfactory provider-patient relationship with a Participating Dentist at locations reasonably accessible to the Member.
    (2) Repeatedly fails to make timely copayments.
c. Knowingly commits fraud. Some examples of fraud include, but are not limited to:

(1) Intentional misuse of ID card (or letting someone else use your ID card to obtain services pretending to be you).
(2) Providing false material or eligibility information with the intent to mislead the Company into providing Benefits it would not otherwise have provided.
(3) Failure to notify the Company of changes that may affect eligibility or benefits.

CONTINUATION OF COVERAGE

A Member's coverage may be continued in certain circumstances when coverage would otherwise be terminated. OEBB's continuation of coverage rules are codified in Chapter 111-050 OAR, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at http://oregon.gov/OHA/OEBB/administrativerules.shtml.

Below is a description of continuation coverage options that may be available to you or your dependents. All options are administered by OEBB. Please refer to OEBB or your Educational Entity for specific details. The Member is responsible for timely payment of premiums and reporting of changes in eligibility or address. Failure to report changes can result in loss of your or your dependents right to continue coverage.

The Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

Federal Family Medical Leave Act

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

Oregon Family Leave Act

OEBB will allow Educational Entities to continue coverage for Active Eligible Employees and covered dependents granted leave under the Oregon Family Leave Act (OFLA) as required under related state rules and regulations. You must notify your Educational Entity within 31 days after the event. Premium may increase by an additional 2% to administer the program. Please contact your Educational Entity or OEBB for further details.

Leave of Absence

OEBB will allow Educational Entities to continue coverage for Active Eligible Employees and covered dependents granted a leave of absence based on collective bargaining agreements and/or documented district policies in effect on or before October 1, 2008. Please contact your Educational Entity or OEBB for further details.

Spouse Continuation of Coverage

According to Oregon law (ORS 743.600), a legally separated, divorced or surviving spouse age 55 or over may elect to continue coverage under this Plan. Children of the spouse may remain covered provided the children are otherwise eligible under this Plan. Please contact your Educational Entity or OEBB for further details.

State Continuation Coverage After Workers' Compensation Claim

If you file a workers' compensation claim for an injury or illness, you may be able to continue coverage for up to 6 months after you would otherwise lose eligibility. Please contact your Educational Entity or OEBB for further details.

During a Labor Dispute

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

a. If an Active Eligible Employee's compensation is suspended or terminated because of a work stoppage caused by a labor dispute, the Plan Administrator will notify the Active Eligible Employee in writing of the right to continue coverage.

b. The Active Eligible Employee must pay Premiums through the Plan Administrator, including the Policyholder's portion.
c. Premium rates during a work stoppage are equal to the Premium rates in place before the work stoppage. The Company may change Premium rates according to the provisions of the Contract. Coverage will terminate on the earlier of:
   (1) The last day of the month for which Premium was paid, if Premiums are unpaid;
   (2) The last day of the 6th month following the date the work stoppage began;
   (3) The last day of the month after the Active Eligible Employee begins full-time employment with another employer; or
   (4) The date of termination of the Contract.

EXTENSION OF BENEFITS

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

Crowns or Bridges

Adjustments for crowns or bridges will be covered for up to 6 months after placement if the final impressions are taken prior to termination 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 and the prosthesis 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 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 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 treatment 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.

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. 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 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.

(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 a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

c. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

d. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

f. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of 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 this regulation 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 that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

c. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

d. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a) For a child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

b) For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial Parent;
The Plan covering the spouse of the Custodial Parent;
The Plan covering the non-custodial parent; and then
The Plan covering the spouse of the non-custodial parent.

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

(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 claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.
b. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-Panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the Reasonable Cash Value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the Reasonable Cash Value of any benefits provided in the form of services.

GENERAL PROVISIONS

Agreement to Provide Benefits

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

Referral to a Specialist

If a Participating Dentist cannot provide a covered service, the Participating Dentist may refer a Member to a Specialist or non-participating Dentist. The Company agrees to provide Benefits for services and supplies provided by a Specialist or non-participating Dentist only if:

a. The Participating Dentist refers the Member;
b. The services and supplies are authorized by the referral; and
c. The services and supplies are listed as covered in the Schedule of Covered Services and Copayments.

Copayments

The Member is responsible for payment of an office visit Copayment for each visit to a Participating Dentist, Specialist, or authorized referral Dentist. Office visit Copayments are payable at each visit.

Some services or supplies may require a service Copayment as described in the Schedule of Covered Services and Copayments. Service Copayments are payable at the time of service.

Participating Employee Dual Coverage

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

EMERGENCY CARE

The Emergency Office Visit Charge Copayment, specified in the Schedule of Covered Services and Copayments, is charged at each visit to seek treatment for a Dental Emergency. If Participating Provider's offices are closed, Enrollee may access after-hours clinical assistance by calling the Appointment Center at 855.4DENTAL (433-6825).

In the event of a Dental Emergency that requires the services of a non-participating dentist located outside of a 50 mile radius of any Participating Provider office, the Company will reimburse to the Member up to $100 for the cost of the services from non-participating dentist's services, less any Copay amounts, to the extent that such services would have been available under this Plan if the Member had used a Participating Dentist. If, in the case of a Dental Emergency, the Member uses a non-participating dentist, requests for Benefits under this Plan must be presented to the Company in writing. The written request for reimbursement must be completely filled out and signed by the Member and the non-participating dentist, and must be accompanied by an itemized statement from the dentist for the services rendered. The Company shall have the right to request additional information from the dentist to process the request, including x-rays and other data. The reimbursement will not be provided if the requested information is not received. All requests must be submitted within 6 months of the date of service.

SUBROGATION

1. Benefits may be available for an injury or disease, which is allegedly the liability of a third party. Such services provided by the Participating Provider are solely to assist the Member. By 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.
2. 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:
   a. Be subrogated to the rights of the Member to recover the Reasonable Cash Value of the Benefits provided in the form of services; and
   b. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Benefits provided in the form of services, subject to the limitations specified below.
3. As a condition of receiving Benefits, the Member shall:
   a. 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;
   b. 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
   c. Take all necessary action to seek and obtain recovery to reimburse the Participating Provider.
4. 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 or supplies provided for treatment of the injury or disease.
5. This Plan does not provide Benefits for services or supplies payable under any motor vehicle medical, motor vehicle no-fault, underinsured or uninsured motorist, personal injury protection, homeowner's, commercial premises coverage, workers' compensation, or other similar plan or insurance.
6. The refusal or failure, without good cause, to cooperate with the Company or Participating Provider is grounds for recovery by the Participating Provider.

COMPLAINTS, GRIEVANCES, AND APPEALS PROCEDURES

Complaints

Members are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider's staff. Most complaints can be resolved with the Participating Provider's staff. If the Member requests a specific service, the Participating Dentist will use his or her judgment to determine if the service is dentally necessary. The Participating Dentist will recommend the most appropriate course of treatment.

Members 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
855.4DENTAL (433-6825)

If the Member remains unsatisfied after discussing with the Participating Dentist or the Member Services Department, grievance and appeal procedures are available for complaints pertaining to a denied Benefit or service.

Grievances

The Member should outline his/her concerns and specific request in writing. The Member may submit comments, documents, and other relevant information. Grievances must be submitted to the Member Services Department within 180 days after the denial of Benefits or services.

a. The Company will review the grievance and all information submitted. The Company will acknowledge receipt of the grievance within 7 business days and will resolve the grievance within 30 calendar days, unless the Member has been notified of a 15 day extension if additional information is needed. If the Benefit request involves:
   (1) A preauthorization, the Company will provide a reply within 15 days.
   (2) Services deemed experimental or investigational, the Company will provide a reply within 20 working days.
   (3) Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 72 hours.
b. If the grievance is denied, the written reply will include information about the basis for the decision; how to appeal; and other disclosures as required under state and federal laws.

Appeals

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

a. The Company will review the appeal and all information submitted. The Company will provide a written reply within 60 days of the receipt. If the appeal involves:
   (1) A preauthorization, the Company will provide a written reply within 30 days.
   (2) Services deemed experimental or investigational, the Company will provide a written reply within 20 working days.
   (3) Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 72 hours.
b. If the appeal is denied, the written reply will include the basis for the decision and other disclosures as required under state and federal laws.

SCHEDULE OF COVERED SERVICES AND COPAYMENTS

Plan Eight

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

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

1. Office Visit Charges

General Office Visit Charge	$20
Specialist Office Visit Charge	$20
Emergency Office Visit Charge	$20

2. Diagnostic and Preventative Services

D0120 Periodic oral evaluation - established patient	None
D0140 Limited oral evaluation - problem focused	None
D0145 Oral evaluation for patient under age 3 and counseling with primary caregiver	None
D0150 Comprehensive oral evaluation - new or established patient	None
D0160 Detailed and 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 (including bitewings)	None
D0220 Intraoral - periapical 1st film	None
D0230 Intraoral - periapical each additional film	None
D0240 Intraoral - occlusal film	None
D0250 Extraoral - 1st film	None
D0260 Extraoral - each additional film	None
D0270 Bitewing - 1 film	None
D0272 Bitewings - 2 films	None
D0273 Bitewings - 3 films	None
D0274 Bitewings - 4 films	None
D0277 Vertical bitewings - 7 to 8 films	None
D0330 Panoramic film	None
D0340 Cephalometric film	None
D0350 Oral/facial photographic images	None
D0425 Caries susceptibility tests	None
D0460 Pulp vitality tests	None
D0470 Diagnostic casts	None
D1110 Prophylaxis - adult	None
D1120 Prophylaxis - child	None
D1203 Topical application of fluoride - child	None
D1204 Topical application of fluoride - adult	None
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	None
D1310 Nutritional counseling for control of dental disease	None
D1320 Tobacco counseling for control and prevention of oral disease	None
D1330 Oral hygiene instructions	None
D1351 Sealant - per tooth	None

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

D1510 Space maintainer - fixed - unilateral	None
D1515 Space maintainer - fixed - bilateral	None
D1520 Space maintainer - removable - unilateral	None
D1525 Space maintainer - removable - bilateral	None
D1550 Re-cementation of space maintainer	None
D1555 Removal of fixed space maintainer	None

4. Restorative Dentistry *(12-month benefit waiting period for Late Enrollees)*

D2140 Amalgam - 1 surface, primary or permanent ..... None
D2150 Amalgam - 2 surfaces, primary or permanent ..... None
D2160 Amalgam - 3 surfaces, primary or permanent ..... None
D2161 Amalgam - 4 or more surfaces, primary or permanent ..... None
D2330 Resin-based composite -1 surface. anterior ..... None
D2331 Resin-based composite -2 surfaces, anterior ..... None
D2332 Resin-based composite - 3 surfaces, anterior ..... None
D2335 Resin-based composite - 4 or more surfaces or involving incisal angle, anterior ..... None
D2390 Resin-based composite crown, anterior ..... None
D2391 Resin-based composite - 1 surface, posterior primary ..... None
D2391 Resin-based composite - 1 surface, posterior permanent ..... None
D2392 Resin-based composite - 2 surfaces, posterior primary ..... None
D2392 Resin-based composite - 2 surfaces, posterior permanent $52
D2393 Resin-based composite - 3 surfaces, posterior primary ..... None
D2393 Resin-based composite - 3 surfaces, posterior permanent $52
D2394 Resin-based composite - 4 or more surfaces, posterior primary ..... None
D2394 Resin-based composite - 4 or more surfaces, posterior permanent $52
D2510 Inlay - metallic - 1 surface ..... None
D2520 Inlay - metallic - 2 surfaces ..... None
D2530 Inlay - metallic - 3 or more surfaces ..... None
D2542 Onlay - metallic - 2 surfaces ..... None
D2543 Onlay - metallic - 3 surfaces ..... None
D2544 Onlay - metallic - 4 or more surfaces ..... None
D2610 Inlay - porcelain/ceramic - 1 surface ..... None
D2620 Inlay - porcelain/ceramic - 2 surfaces ..... None
D2630 Inlay - porcelain/ceramic - 3 or more surfaces ..... None
D2642 Onlay - porcelain/ceramic - 2 surfaces ..... None
D2643 Onlay - porcelain/ceramic - 3 surfaces ..... None
D2644 Onlay - porcelain/ceramic - 4 or more surfaces ..... None

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

D2710 Crown - resin-based composite (indirect) ..... None
D2740 Crown - porcelain/ceramic substrate ..... None
D2750 Crown - porcelain fused to high noble metal ..... None
D2752 Crown - porcelain fused to noble metal ..... None
D2782 Crown - ¾ cast noble metal ..... None
D2910 Recement inlay, onlay, or partial coverage restoration ..... None
D2920 Recement 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 ..... None
D2951 Pin retention - per tooth, in addition to restoration ..... None
D2954 Prefabricated post and core in addition to crown ..... None
D2955 Post removal (not in conjunction with endodontic therapy) ..... None
D2957 Each additional prefabricated post - same tooth ..... None
D2970 Temporary crown (fractured tooth) ..... None
D2980 Crown repair, by report ..... None

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

D3110 Pulp cap - direct (excluding final restoration) ..... None
D3120 Pulp cap - indirect (excluding final restoration) ..... None

D3220 Therapeutic pulpotomy(excluding final restoration) - - removal of pulp coronal to the dentinocemental junction and application of medicament ..... None
D3221 Pulpal debridement, primary and permanent teeth ..... None
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) ..... None
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) ..... None
D3310 Endodontic therapy - anterior tooth (excluding final restoration) ..... 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 root repair of perforation defects ..... None
D3346 Retreatment of previous root canal therapy - anterior ..... None
D3347 Retreatment of previous root canal therapy - bicuspid ..... None
D3348 Retreatment of previous root canal therapy - molar ..... None
D3351 Apexification/recalcification/pulpal regeneration - initial visit ..... None
D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement ..... None
D3353 Apexification/recalcification - final visit ..... None
D3410 Apicoectomy/periradicular surgery - anterior ..... None
D3421 Apicoectomy/periradicular surgery - bicuspid (1st root) ..... None
D3425 Apicoectomy/periradicular surgery - molar (1st root) ..... None
D3426 Apicoectomy/periradicular surgery (each additional root) ..... None
D3430 Retrograde filling - per root ..... None
D3450 Root amputation - per tooth ..... None
D3920 Hemisection (including any root removal), not including root canal therapy ..... None
D3950 Canal preparation and fitting of preformed dowel or post ..... None

7. Periodontics (*12-month benefit waiting period for Late Enrollees)*
D4210 Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant ..... None
D4211 Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant ..... None
D4240 Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant ..... None
D4241 Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrantNone
D4249 Clinical crown lengthening - hard tissue ..... None
D4260 Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant ..... None
D4261 Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant ..... None
D4263 Bone replacement graft - 1st site in quadrant ..... None
D4264 Bone replacement graft - each additional site in quadrant ..... None
D4270 Pedicle soft tissue graft procedure ..... None
D4271 Free soft tissue graft procedure (including donor site surgery) ..... None
D4273 Subepithelial connective tissue graft procedures, per tooth ..... None
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) ..... None
D4341 Periodontic scaling and root planing - 4 or more teeth per quadrant ..... None
D4342 Periodontal scaling and root planing - 1 to 3 teeth per quadrant ..... None
D4355 Full-mouth debridement to enable comprehensive evaluation and diagnosis ..... None
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report ..... None
D4910 Periodontic maintenance ..... None

8. Prosthodontics – Removable *(12-month benefit waiting period for Late Enrollees)*
D5110 Complete denture -maxillary ..... None
D5120 Complete denture - mandibular ..... None
D5130 Immediate denture -maxillary ..... None
D5140 Immediate denture - mandibular ..... None

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ..... None
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ..... None
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ..... None
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ..... None
D5281 Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth) ..... None
D5410 Adjust - complete denture - maxillary ..... None
D5411 Adjust - complete denture - mandibular ..... None
D5421 Adjust - partial denture - maxillary ..... None
D5422 Adjust - partial denture - mandibular ..... None
D5510 Repair broken complete denture base ..... None
D5520 Replace missing or broken teeth - complete denture (each tooth) ..... None
D5610 Repair resin denture base ..... None
D5620 Repair cast framework ..... None
D5630 Repair or replace broken clasp ..... None
D5640 Replace broken teeth - per tooth ..... None
D5650 Add tooth to existing partial denture ..... None
D5660 Add clasp to existing partial denture ..... None
D5710 Rebase complete maxillary denture ..... None
D5711 Rebase complete mandibular denture ..... None
D5720 Rebase maxillary partial denture ..... None
D5721 Rebase mandibular partial denture ..... None
D5730 Reline complete maxillary denture (chairside) ..... None
D5731 Reline complete mandibular denture (chairside) ..... None
D5740 Reline maxillary partial denture (chairside) ..... None
D5741 Reline mandibular partial denture (chairside) ..... None
D5750 Reline complete maxillary denture (laboratory) ..... None
D5751 Reline complete mandibular denture (laboratory) ..... None
D5760 Reline maxillary partial denture (laboratory) ..... None
D5761 Reline mandibular partial denture (laboratory) ..... None
D5810 Interim complete denture (maxillary) ..... None
D5811 Interim complete denture (mandibular) ..... None
D5820 Interim partial denture (maxillary) ..... None
D5821 Interim partial denture (mandibular) ..... None
D5850 Tissue conditioning, maxillary ..... None
D5851 Tissue conditioning, mandibular ..... None
D5860 Overdenture - complete, by report ..... None
D5861 Overdenture - partial, by report ..... None
D5986 Fluoride gel carrier ..... None

9. Prosthodontics – Fixed *(12-month benefit waiting period for Late Enrollees)*
D6210 Pontic - cast high noble metal ..... None
D6240 Pontic - porcelain fused to high noble metal ..... None
D6241 Pontic - porcelain fused to predominately base metal ..... None
D6545 Retainer - cast metal for resin bonded fixed prosthesis ..... None
D6720 Crown - resin with high noble metal ..... None
D6750 Crown - porcelain fused to high noble metal ..... None
D6780 Crown - ¾ cast high noble metal ..... None
D6790 Crown - full cast high noble metal ..... None
D6930 Recement fixed partial denture ..... None
D6972 Prefabricated post and core in addition to fixed partial denture retainer ..... None
D6973 Core build up for retainer, including any pins ..... None
D6975 Coping - metal ..... None
D6980 Fixed partial denture repair, by report ..... None

10. Oral Surgery *(12-month benefit waiting period for Late Enrollees)*

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

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

D9220 Deep sedation/general anesthesia - 1st 30 minutes ..... Not Covered
D9221 Deep sedation/general anesthesia - Each additional 15 minutes ..... Not Covered
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis (per visit).....$15

12. Miscellaneous

D9110 Palliative (emergency) treatment of dental pain - minor procedure..... None
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician ... None
D9420 Hospital or ambulatory surgical center call (Service Copays still apply and facility fees not covered.) *.....$100
D9430 Observation visit (during regularly scheduled hours) - no other services performed ..... None
D9440 Visit - after regularly scheduled hours $20
D9910 Application of desensitizing medicaments *..... None
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth *..... None
D9951 Occlusal adjustment – limited *..... None
D9970 Enamel microabrasion *..... None
Out-of-area emergency treatment is reimbursed up to $100 minus applicable copays.

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

ORTHODONTIC SERVICES

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

Benefits for orthodontic treatment are provided only if the Participating Dentist prepares the treatment plan prior to rendering services. The treatment plan is based on an examination that must take place while the Member is covered under this Plan. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

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

If Benefits for orthodontic services terminate prior to completion of orthodontic treatment, Benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the copayment may be prorated. The services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

The Member is responsible for payment of the applicable Copayments listed below for pre-orthodontic and orthodontic services and for services connected with orthodontic treatment. The Pre-Orthodontic Service Copayments will be deducted from the Comprehensive Orthodontic Service Copayment, if the Member accepts the treatment plan.

Orthodontic Office Visit Copay

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

- Plan 8 Orthodontic Office Visit Copay $20

Pre-Orthodontic Service Copay

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

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

Orthodontic Service Copay

- Comprehensive Orthodontic Service Copay $1,500

The following are procedures provided under the Benefits for orthodontic services:

D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8691 Repair of orthodontic appliance

IMPLANT SERVICES

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

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

If coverage under this Plan terminates prior to completion of implant treatment (including the application of the prosthetic(s)), there may be additional charges for implant services rendered 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. Continuing implant treatment (including the application of the 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 the Schedule of Covered Services and Copayments. All Copayments must be paid in full at the time of service. In addition, only the implant services and supplies listed below will be covered under the Implant Services Benefit. All other implant services will be subject to the Copayments, including any Office Visit Copayments, stated in the Schedule of Covered Services and Copayments or will not be covered.

D6010 Surgical placement of implant body: endosteal implant	$1,800
D6053 Implant/abutment supported removable denture for completely edentulous arch	$1,690
D6054 Implant/abutment supported removable partial for partially edentulous arch	$1,690
D6055 Connecting bar - implant supported or abutment supported	None
D6056 Prefabricated abutment - includes placement	None
D6057 Custom abutment - includes placement	None
D6059 Abutment supported porcelain fused to metal crown (high noble metal)	$1,380*
D6062 Abutment supported cast metal crown (high noble metal)	$1,380*
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$1,015
D6072 Abutment supported retainer for cast metal FPD (high noble metal)	$1,015
D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	None
D6090 Repair implant supported prosthesis, by report	None
D6095 Repair implant abutment, by report	None
D6190 Radiographic/surgical implant index, by report	None
D6240 Pontic - porcelain fused to high noble metal	None

* **Two Teeth Implant:** The total amount of Implant Service Copayments incurred by a Member for procedures associated with a two teeth implant delivered on the same date of service shall not exceed $5,630 under the Implant Services Benefit. This amount shall not include additional fees incurred by the Member for services not covered under the Implant Services Benefit.

Three Teeth Implant: The total amount of Implant Service Copayments incurred by a Member for procedures associated with a three teeth implant delivered on the same date of service shall not exceed $7,875 under the Implant Services Benefit. This amount shall not include additional fees incurred by the Member for services not covered under the Implant Services Benefit.

EXCLUSIONS AND LIMITATIONS

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

Exclusions

- Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage, including the following:
    a. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under this Plan; or
    b. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under this Plan.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Exams or consultations needed solely in connection with a service or supply not listed as covered.
- Experimental or investigational services or supplies and related exams or consultations.
- Full mouth reconstruction , including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia or moderate sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services or supplies, 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 are not a benefit.
- 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 or supplies and related exams or consultations that are not within of the prescribed treatment plan and/or are not recommended and approved by the Participating Dentist.
- Services or supplies and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant within the scope of his or her license.
- Services or supplies for the diagnosis or treatment of temporomandibular joint disorders.
- Services or supplies for treatment of injuries sustained while practicing for or competing in a paid athletic contest of any kind.
- Services or supplies for treatment of intentionally self-inflicted injuries.
- Services or supplies for 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 or supplies for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services or supplies provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons.
- Services or supplies that are not listed as covered.
- Services or supplies where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

Alternate Services. If alternative services can be used to treat a condition, the service recommended by the Participating Dentist is covered. In the event the Member elects a service that is more costly than the service the Participating Dentist has approved, the Member is responsible for the Copayment for the recommended covered service plus the cost differential between Reasonable Cash Value of the recommended service and Reasonable Cash Value of the more costly requested service.

Congenital Malformations. Services or supplies listed in this Certificate, which are provided to correct congenital or developmental malformations of the teeth and supporting structure, will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.

Endodontic Retreatment.

a. When initial root canal therapy was performed by a Participating Dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable Copayments will apply.
b. When the initial root canal therapy was performed by a non-participating Dentist, the retreatment of such root canal therapy by a Participating Dentist 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:

a. A hospital or similar setting is medically necessary.
b. The services are pre-authorized in writing by a Participating Dentist.
c. The services provided are the same services that would be provided in a dental office.
d. The Hospital Call Copayment and other applicable Copayments are paid.

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

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

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

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