Willamette Dental Group

CERTIFICATE OF COVERAGE

Effective: January 1, 2021

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Willamette Dental Group

Underwritten by Willamette Dental of Washington, Inc.
002-WA733(1/21)

Willamette Dental Group

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: **1.855.433.6825**

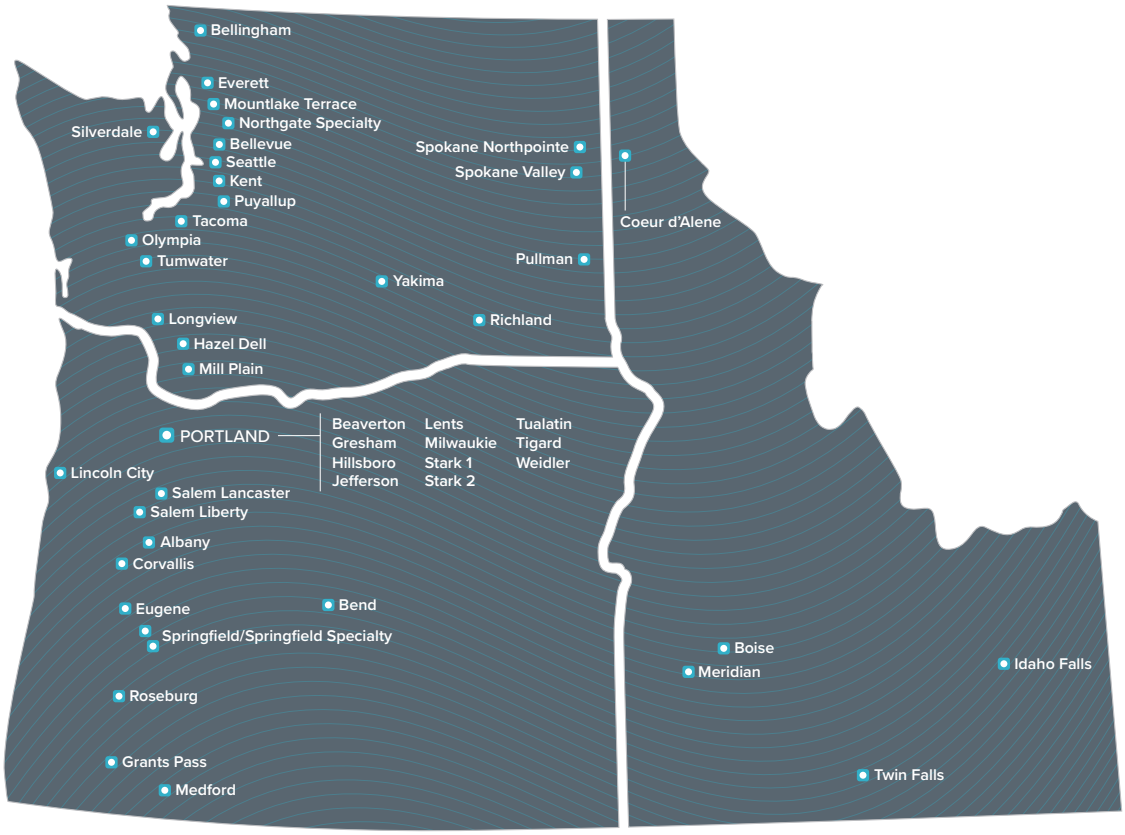
Member Services

Monday - Friday 8am to 5pm PT

Toll Free: **1.855.433.6825**

E-mail: memberservices@willamettedental.com

willamettedental.com/sebb



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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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If any information in this Certificate of Coverage is inconsistent with the provisions of the contract between Willamette Dental and the Policyholder, this Certificate of Coverage will control.

Effective: January 1, 2021 • Group Plan Number WA733

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

Section 1 Definitions

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

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

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

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

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

1.6 **"Dependent"** means a person who meets eligibility requirements in Washington Administrative Code (WAC) 182-31-140 for SEBB Benefits and is enrolled for coverage.

1.7 **"Enrollee"** means a person who meets all eligibility requirements defined in chapter 182-31 WAC, who is enrolled in this Plan, and for whom applicable premium payments have been made.

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

- Whether the services are in general use in the dental community in the State of Washington;
- Whether the services are under continued scientific testing and research;
- Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
- Whether the services are proven safe and effective.

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

1.10 **"HCA"** means the Washington State Health Care Authority.

1.11 **"Non-Participating Provider"** means a Dentist or Denturist, who is not employed by or under member with Willamette Dental or Participating Provider to provide dental services.

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

1.13 **"Plan"** means this SEBB dental benefit plan of coverage.

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

1.15 **"School Employee"** means all employees of school districts, educational service districts, and charter schools established under chapter 28A.710 Revised Code of Washington (RCW).

1.16 **"School Employees Benefits Board Organization"** or **"SEBB Organization"** means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the School Employees Benefits Board.

1.17 **"SEBB"** means the School Employees Benefits Board established in RCW 41.05.740.

1.18 **"SEBB Benefits"** means one or more insurance coverages or other school employee benefits administered by the SEBB Program within the HCA.

1.19 **"SEBB Program"** means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040) and eligible dependents (as described in WAC 182-31-140).

1.20 **"Service Copayment"** means the Copayment the Enrollee must pay for each dental service. Service Copayments are in addition to the General Office Visit Copayment or the Specialist Office Visit Copayment.

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

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

1.23 **"Subscriber"** means the employees of school districts, educational service districts, and charter schools established under chapter 28A.710 RCW or continuation coverage enrollee who has been determined eligible by the SEBB Program or SEBB Organizations and is the individual to whom the SEBB Program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an Enrollee.

1.24 **"Willamette Dental"** means Willamette Dental of Washington, Inc.

Section 2 Dental Plan Eligibility and Enrollment

In these sections, “health plan” is used to refer to a plan offering medical, vision, or dental coverage, or a combination developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The school employee’s SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee’s right to appeal eligibility and enrollment decisions. Information about a school employee’s right to an appeal can be found on page 12 of this Certificate of Coverage. For information on how to enroll see the “Enrollment” section.

Eligible Dependents

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the “Enrollment” section. The SEBB Program or SEBB Organization verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent’s eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in the state statute and substantially equivalent legal unions from other jurisdictions as defined in the Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber’s:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. Children of the subscriber’s spouse, based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
    c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    d. Children of the subscriber’s state-registered domestic partner, based on the state-registered domestic partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber’s legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
    e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
    f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber’s spouse, or subscriber’s state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber’s spouse, or the subscriber’s state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26. The following requirements apply to dependents with a disability:
   - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
   - The subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection;
   - A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;
   - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
   - The SEBB Program (with input from the medical plan if enrolled in medical) will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment

A subscriber or their dependent is eligible to enroll in only one SEBB dental plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same or different SEBB Organizations may be enrolled as a dependent under both parents but is limited to a single enrollment in SEBB dental.

A school employee is <u>required</u> to enroll in a dental plan under their SEBB Organization. A school employee must submit their enrollment online in SEBB My Account or return a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits. The form must be received no later than 31 days after the date the school employee becomes eligible. If the school employee does not return the School Employee Enrollment/Change form by the deadline, the school employee will be enrolled in Uniform Dental Plan and any eligible dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when an event occurs that creates a special open enrollment.

How to enroll

A school employee must submit their enrollment online in SEBB My Account or return a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits.

To enroll an eligible dependent, the school employee must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. A dependent must be enrolled in the same health plan coverage as the subscriber. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program or the SEBB Organization is unable to verify their eligibility within the SEBB Program enrollment timelines.

All other subscribers may enroll by submitting the required forms to the SEBB Program. The SEBB Program must receive the school employee's elections no later than 60 days from the date the school employee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB Program, whichever is later. The school employee's first premium payment and applicable premium surcharges are due no later than 45 days after the election ends as described above. Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB medical, dental and vision insurance coverage. For more information see "Options for continuing SEBB dental coverage" on page 9.

A subscriber or their dependents may also enroll during the SEBB Program's annual open enrollment (see "Annual open enrollment" on page 6) or during a special open enrollment (see "Special open enrollment" beginning on page 6). The subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove dependents within 60 days of the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible Dependents" on page 3. **All other subscribers** must notify the SEBB Program **to remove a dependent** within 60 days of the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible Dependents" on page 3. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent losing eligibility to continue SEBB dental coverage under one of the continuation coverage options described on page 9 of this Certificate of Coverage;
- The subscriber being billed for claims paid by the dental plan that were received after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's dental plan coverage after the dependent lost eligibility.

When dental coverage begins

For a school employee and their eligible dependents **enrolling when the school employee is newly eligible**, SEBB dental coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

1. The school employee's benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.
2. When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, the SEBB benefits begin on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a subscriber or their eligible dependents **enrolling during a special open enrollment**, SEBB dental coverage begins the first day of the month following the later of the event date or the date the online enrollment or required form is received.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, dental coverage begins as follows:
    a. For an employee, dental coverage will begin the first day of the month in which the event occurs;
    b. For the newly born child, dental coverage begins the date of birth; or
    c. For a newly adopted child, dental coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;
    d. For a spouse or state-registered domestic partner of a subscriber, dental coverage will begin the first day of the month in which the event occurs.
    e. Enrollment of an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

Annual open enrollment

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll or remove eligible dependents
- Change their dental plan

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll in or terminate enrollment in a dental plan
- Enroll or remove eligible dependents
- Change their dental plan

The school employee must submit the change online in SEBB My Account or return the required enrollment/change form to their SEBB Organization. All other subscribers must submit the form to the SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. A special open enrollment event must be an event other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits. The special open enrollment may allow a subscriber to:

- Change their dental plan
- Enroll or remove eligible dependents

To make an enrollment change, the school employee must make the change online in SEBB My Account or submit the required forms to their SEBB Organization. All other subscribers must submit the form(s) to the SEBB Program. The forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the SEBB Program or SEBB Organization will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the school employee should notify their SEBB Organization by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their payroll or benefits office for the required forms.
See "When may a subscriber enroll or remove eligible dependents?" on page 8.

When can a subscriber change their health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber has a change in employment from a SEBB Organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:
    a. The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or
    b. The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.
    c. As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.
5. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan otherwise there will be limited accessibility to network providers and covered services;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;

10. Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in Medicare, the subscriber must select a new medical plan;
11. Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
12. Subscriber or their dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber or a subscriber's dependent physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment of a high risk pregnancy.

Note: If an enrollee's provider or dental care facility discontinues participation with the dental plan, the enrollee may not change dental plans until the SEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the SEBB Program determines that a continuity of care issue exists. This plan cannot guarantee that any dentist, facility, or other provider will be available or remain under contract with us.

When may a subscriber enroll or remove eligible dependents?
Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
5. Subscriber or a subscriber's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;
7. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);

8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP) program, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.

When dental coverage ends

Dental coverage ends on the following dates:

1. The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
2. The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
3. The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

Premium payments and applicable premium surcharges become due the first of the month in which dental coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their health plan before the end of the month.

When dental plan enrollment ends, the enrollee may be eligible for continuation coverage if they apply within the timelines explained in the "Options for continuing SEBB dental coverage" on page 9.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or applicable premium surcharge. If the subscriber is not eligible for the employer contribution and has premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the subscriber's dental coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.

A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other subscribers may call the SEBB Program at the 1-800-200-1004.

Medicare eligibility and enrollment

If a school employee or their dependent becomes eligible for Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

Options for continuing SEBB dental coverage

A school employee and their dependent covered by this dental plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB dental plan enrollees:

1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's SEBB dental plan coverage ends due to a qualifying event. SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types. Enrollees who qualify for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

You must notify the SEBB Program in writing within 30 days if, after electing COBRA, you or your dependent become enrolled in Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. If a subscriber enrolls in COBRA and then become eligible for Medicare, their enrollment in COBRA coverage will be terminated when the subscriber is eligible for Medicare. This may cause the COBRA coverage to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. Subscribers who are already enrolled in Medicare when they enroll in COBRA will not have their coverage terminated early.

The SEBB Program administers both continuation coverage options. Refer to the *SEBB Continuation Coverage Election Notice* for details.

Option for coverage under Public Employees Benefits Board (PEBB) retiree insurance

A retiring school employee is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional continuation coverage

School employees and their dependents may gain temporary eligibility for School Employees Benefits Board (SEBB) benefits, on a self-pay basis, if they meet the following criteria:

1. A school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to enroll in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of eighteen months.
2. A dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019, who loses eligibility because they are not an eligible dependent may enroll in medical, dental, and vision for a maximum of thirty-six months.
3. A dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019, may elect to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For more information on continuation coverage, see the section titled “Options for continuing SEBB dental coverage” on page 9.

Paid Family Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program may continue to receive the employer contribution toward SEBB benefits in accordance with the Paid Family and Medical Leave Program. The Employment Security Department determines if the school employee is eligible for the Paid Family and Medical Leave Program. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under the Paid Family and Medical Leave Program, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled “Options for Continuing SEBB Dental Coverage” on page 9.

General provisions

Payment of premium during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly to the Health Care Authority (HCA) if the school employee’s compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the school employee’s compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due. Thereafter, if coverage is no longer available, then the Subscriber may purchase an individual dental plan from Willamette Dental of Washington, Inc., if available, at a premium rate consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Termination of Enrollment for Cause

An Enrollee may have coverage terminated under this Plan for misconduct. Examples of such misconduct include, but are not limited to the following:

1. Fraud, intentional misrepresentation or withholding of information for the purpose of defrauding Willamette Dental or this Plan.
2. Abusive or threatening conduct directed to a health plan, Participating Provider or Willamette Dental, its employees, or other persons.
3. Repeated failure to make timely payment of Copayments.

Upon termination from this Plan, contact the SEBB program for enrollment possibilities.

Appeal rights

Any current or former school employee of a SEBB Organization or their dependent may appeal a decision made by the SEBB Organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB Organization.

Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of a SEBB dental plan by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment decisions.

Section 3 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.

3.1 The Order of Benefit Determination Rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense.

3.2 Definitions

a. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
   1. Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group or individual coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.
   3. Each contract for coverage under 1 or 2 is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

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

c. The Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one plan. When This Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When This Plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

d. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. The Allowable Expense for the Secondary Plan is the amount it allows for the service in the absence of other coverage that is primary.

e. The following are examples of expenses that are not Allowable Expenses:
    1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
    2. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
    3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

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

3.3 Order of Benefit Determination Rules. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. Except as provided in subsection c, a plan that does not contain a coordination of benefits provision that is consistent with state regulation regarding coordination of benefits is always primary unless the provisions of both plans state that the complying plan is primary.

c. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

e. Each plan determines its order of benefits using the first of the following rules that apply:

1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.
2. Dependent Child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
   (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
      (ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
      (iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;
      (iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or
      (v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The plan covering the Custodial Parent, first;
         - The plan covering the spouse or state-registered domestic partner of the Custodial Parent, second;
         - The plan covering the noncustodial parent, third; and then

- The plan covering the spouse or state-registered domestic partner of the noncustodial parent, last.

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

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section e.1. can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section e.1. can determine the order of benefits.
5. Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

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

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

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

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

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

Section 4 Subrogation

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

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

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

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

a. Provide the Plan and Participating Provider with the name and address of the parties liable, all facts known concerning the injury or disease, 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 Plan's and Participating Provider's subrogation rights; and
c. Take all necessary action to seek and obtain recovery to reimburse the Plan and Participating Provider for the Reasonable Cash Value of the Covered Services.

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

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

Section 5 Complaints, Grievances, and Appeals

5.1 Complaints.

a. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider and Participating Provider's staff. Most matters can be resolved with the Participating Provider and Participating Provider's staff.

b. If the Enrollee requests a specific service, the Participating Provider will use his/her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.

c. Enrollees may also contact the Member Services Department with questions or complaints at:

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

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

5.2 Grievances.

a. A grievance is a complaint expressing dissatisfaction with a service provided by the Plan or other matters related to the Plan. The Enrollee should outline his/her concerns and specific request in writing. The Enrollee may submit comments, documents, and other relevant information. Grievances must be submitted to the Member Services Department no later than 180 days after the event occurred.

b. The Plan will review the grievance and all information submitted. The Plan will provide a written reply no later than 30 days after receipt. If additional time is needed, the Plan will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws. If the grievance involves:

   1. A preauthorization, the Plan will provide a written reply no later than 15 days after the receipt of a written grievance.
   2. Services deemed Experimental or Investigational, the Plan will provide a written reply no later than 20 working days after the receipt of a written grievance.
   3. Services not yet provided for an alleged Dental Emergency, the Plan will provide a reply no later than 72 hours of the receipt of a written grievance.

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

5.3 Appeals.

a. An appeal is a request for review of a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. An appeal must be submitted in writing to the Member Services Department no later than 180 days after the date of the denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information.

b. The Plan will review the appeal and all information submitted. The Plan will provide a written reply no later than 60 days after the receipt of a written request for an appeal. If the appeal involves:

1. A preauthorization, the Plan will provide a written reply no later than 30 days after the receipt of a written request for an appeal.
2. Services deemed Experimental or Investigational, the Plan will provide a written reply no later than 20 working days after the receipt of a written request for an appeal.
3. Services not yet provided for an alleged Dental Emergency, the Plan will provide a reply no later than 72 hours of the receipt of a written request for an appeal.

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

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

Section 6 General Provisions

6.1 Rights Not Transferable. The benefits of the Plan are not transferable.

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

6.3 Waiver and Severability. If Willamette Dental does not enforce a provision of the Plan, it will not constitute a waiver of that or any other provision at any time in the future. If any provision of the Plan is declared unenforceable by a court having jurisdiction, the provision is ineffective only to the extent declared unenforceable. The remainder of the provision and all other provisions of the

6.4 Statements. In the absence of fraud, statements made by an Enrollee are representations which Willamette Dental may rely upon. Statements made for the purpose of acquiring coverage will not void the coverage or reduce benefits, unless contained in a written instrument signed by the Enrollee.

6.5 Relationship to Law and Regulations. Any provision of this Certificate of Coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Section 7 Dental Coverage

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

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

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

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

7.4 **Dental Emergency While Out of Area.** The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider office. The Plan will reimburse the Enrollee up to the out of area emergency reimbursement amount less any Copayments specified in Appendix A for the cost of the Covered Services. The Enrollee must submit a written request for reimbursement to Willamette Dental no later than 6 months after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested by Willamette Dental to process the request. The benefit for out of area Dental Emergency treatment will not be provided if the requested information is not received.

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

a. **Crowns or Bridges.** Adjustments for crowns or bridges will be covered for up to 6 months after placement, if the final impressions are taken prior to termination and the crown or bridge is placed no later than 60 days after termination.
b. **Removable Prosthetic Devices.** Adjustments for removable prosthetic devices will be covered for up to 6 months after placement, if final impressions are taken prior to termination and the prosthesis is delivered no later than 60 days after termination. Laboratory relines are not covered after termination.

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

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

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

Section 8 Exclusions and Limitations

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

a. 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.

b. The completion or delivery of treatments or services performed or initiated prior to the effective date of coverage under the Plan, including the following:
   1. Endodontic services and prosthodontic services;
   2. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Plan; or
   3. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under the Plan.

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

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

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

e. Experimental or Investigational services and related exams or consultations.

f. 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.

g. Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees, except as covered under Section 8.2 e.

h. Maxillofacial prosthetic services.

i. Nitrous oxide.

j. Personalized restorations.

k. Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance. This includes, but is not limited to laminates, veneers, or tooth bleaching.

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

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

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

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

p. Replacement of sound restorations or replacement of restorations when there no defects present in the restoration.

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

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

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

t. Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.

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

v. Services for the treatment of intentionally self-inflicted injuries.
w. Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
x. Services that are not listed as covered in the appendices.
y. Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

8.2 Limitations.

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

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

c. **Endodontic Retreatment.** When the initial root canal therapy was performed by the Participating Provider, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. After 24 months, the applicable Copayments will apply. When the initial root canal therapy was performed by a Non-Participating Provider, the retreatment of such root canal therapy by the Participating Provider will be subject to the applicable Copayments.

d. **General Anesthesia.** General anesthesia is covered with the Copayments specified in Appendix A only if the following criteria are met:
   1. It is performed in a dental office;
   2. It is provided in conjunction with a Covered Service; and
   3. The Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically handicapped.

e. **Hospital Setting.** The services provided by a Dentist in a hospital setting are covered if the following criteria are met:
   1. The Participating Provider determines a hospital or similar setting is medically necessary;
   2. The services are authorized in writing by the Participating Provider;
   3. The services provided are the same services that would be provided in a dental office; and
   4. The applicable Copayments are paid.

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

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

Appendix A - Schedule of Covered Services and Copayments

Office Visit Copayments

General Office Visit Copayment $0
Specialist Office Visit Copayment..... $0

Code	Procedure	Enrollee Pays
1. Diagnostic and Preventive Services		
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under 3 years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed & extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral – periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0
D0350	2D oral/facial photographic image obtained intraorally or extraorally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
2. Space Maintainers		
D1510	Space maintainer - fixed - unilateral – per quadrant	$20
D1516	Space maintainer - fixed - bilateral, maxillary	$30
D1516	Space maintainer - fixed - bilateral, mandibular	$30
D1520	Space maintainer - removable - unilateral – per quadrant	$20

D1526	Space maintainer - removable - bilateral, maxillary	$30
D1526	Space maintainer - removable - bilateral, mandibular	$30
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$10
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0
D1557	Removal of fixed bilateral space maintainer - maxillary	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	$0

3. Restorative Services

D2140	Amalgam - 1 surface, primary or permanent	$10
D2150	Amalgam - 2 surfaces, primary or permanent	$10
D2160	Amalgam - 3 surfaces, primary or permanent	$10
D2161	Amalgam - 4 or more surfaces, primary or permanent	$10
D2330	Resin-based composite - 1 surface, anterior	$15
D2331	Resin-based composite - 2 surfaces, anterior	$15
D2332	Resin-based composite - 3 surfaces, anterior	$15
D2335	Resin-based composite - 4 or more surfaces involving incisal angle (anterior)	$15
D2390	Resin-based composite crown, anterior	$50
D2391	Resin-based composite - 1 surface, posterior	$50
D2392	Resin-based composite - 2 surfaces, posterior	$50
D2393	Resin-based composite - 3 surfaces, posterior	$50
D2394	Resin-based composite - 4 or more surfaces, posterior	$50
D2510	Inlay - metallic - 1 surface	$115
D2520	Inlay - metallic - 2 surfaces	$115
D2530	Inlay - metallic - 3 or more surfaces	$115
D2542	Onlay - metallic - 2 surfaces	$125
D2543	Onlay - metallic - 3 surfaces	$125
D2544	Onlay - metallic - 4 or more surfaces	$125
D2610	Inlay - porcelain/ceramic - 1 surface	$125
D2620	Inlay - porcelain/ceramic - 2 surfaces	$125
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$125
D2642	Onlay - porcelain/ceramic - 2 surfaces	$125
D2643	Onlay - porcelain/ceramic - 3 surfaces	$125
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$125

4. Crowns

D2710	Crown - resin based composite (indirect)	$100
D2740	Crown - porcelain/ceramic	$155
D2750	Crown - porcelain fused to high noble metal	$175
D2780	Crown - ¾ cast high noble metal	$175
D2790	Crown - full cast high noble metal	$150
D2799	Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$100
D2931	Prefabricated stainless steel crown - permanent tooth	$100
D2932	Prefabricated resin crown	$100

D2933	Prefabricated stainless steel crown with resin window	$100
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated	$0
D2954	Prefabricated post and core in addition to crown	$0
D2955	Post removal	$0
D2957	Each additional prefabricated post - same tooth	$0
D2970	Temporary crown (fractured tooth)	$0
D2975	Coping	$0
D2980	Crown repair necessitated by restorative material failure	$0

5. Endodontics

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$100
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$125
D3330	Endodontic therapy, molar (excluding final restoration)	$150
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$100
D3347	Retreatment of previous root canal therapy - premolar	$125
D3348	Retreatment of previous root canal therapy - molar	$150
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$10
D3352	Apexification/recalcification - interim medication replacement	$10
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$10
D3410	Apicoectomy - anterior	$70
D3421	Apicoectomy - premolar (first root)	$50
D3425	Apicoectomy - molar (first root)	$50
D3426	Apicoectomy (each additional root)	$50
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$50
D3920	Hemisection (including any root removal), not including root canal therapy	$100
D3950	Canal preparation and fitting of a preformed dowel or post	$0

6. Periodontics

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$75
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$35

D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$100
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$75
D4249	Clinical crown lengthening - hard tissue	$100
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$100
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$75
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$100
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$100
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$100
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$100
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in same graft site	$100
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$35
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$15
D4346	Scaling in presences of generalized moderate or severe gingival inflammations – full mouth, after oral evaluation	$0
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$25
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0
D4910	Periodontal maintenance	$35

7. Prosthodontics - Removable

D5110	Complete denture - maxillary	$140
D5120	Complete denture - mandibular	$140
D5130	Immediate denture - maxillary	$140
D5140	Immediate denture - mandibular	$140
D5211	Maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$140
D5212	Mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$140
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$140
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$140
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	$140
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	$140

D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5511	Repair broken complete denture base, mandibular	$15
D5512	Repair broken complete denture base, maxillary	$15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15
D5611	Repair resin partial denture base, mandibular	$0
D5612	Repair resin partial denture base, maxillary	$0
D5621	Repair cast partial framework, mandibular	$15
D5622	Repair cast partial framework, maxillary	$15
D5630	Repair or replace broken retentive/clasping materials – per tooth	$30
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture – per tooth	$30
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$60
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$60
D5710	Rebase complete maxillary denture	$60
D5711	Rebase complete mandibular denture	$60
D5720	Rebase maxillary partial denture	$60
D5721	Rebase mandibular partial denture	$60
D5730	Reline complete maxillary denture (chairside)	$40
D5731	Reline complete mandibular denture (chairside)	$40
D5740	Reline maxillary partial denture (chairside)	$40
D5741	Reline mandibular partial denture (chairside)	$40
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$70
D5811	Interim complete denture (mandibular)	$70
D5820	Interim partial denture (maxillary)	$70
D5821	Interim partial denture (mandibular)	$70
D5850	Tissue conditioning, maxillary	$15
D5851	Tissue conditioning, mandibular	$15
D5863	Overdenture - complete maxillary	$140
D5864	Overdenture - partial maxillary	$140
D5865	Overdenture - complete mandibular	$140
D5866	Overdenture - partial mandibular	$140
D5986	Fluoride gel carrier	$0

8. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$175
D6240	Pontic - porcelain fused to high noble metal	$175
D6241	Pontic - porcelain fused to predominantly base metal	$125
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$125
D6720	Retainer crown - resin with high noble metal	$125
D6750	Retainer crown - porcelain fused to high noble metal	$175
D6780	Retainer crown - ¾ cast high noble metal	$175

D6790	Retainer crown - full cast high noble metal	$175
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$65
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

9. Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	$10
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10
D7220	Removal of impacted tooth - soft tissue	$30
D7230	Removal of impacted tooth - partially bony	$40
D7240	Removal of impacted tooth - completely bony	$50
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$50
D7250	Removal of residual tooth roots (cutting procedure)	$50
D7260	Oroantral fistula closure	$50
D7261	Primary closure of a sinus perforation	$50
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Exposure of an unerupted tooth	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$50
D7286	Incisional biopsy of oral tissue - soft	$0
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$50
D7510	Incision & drainage of abscess - intraoral soft tissue	$0
D7520	Incision & drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$0
D7670	Alveolus - closed reduction, may include stabilization of teeth	$0
D7910	Suture of recent small wounds up to 5 cm	$0
D7911	Complicated suture - up to 5 cm	$0
D7953	Bone replacement graft for ridge preservation - per site	$0
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another	$50
D7970	Excision of hyperplastic tissue - per arch	$50
D7971	Excision of pericoronal gingiva	$50
	Orthognathic surgery for treatment of congenital anomalies for enrolled Children under age 19 - Subject to a lifetime benefit maximum of $5,000	30% of charges

10. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15
D9120	Fixed partial denture sectioning	$0
D9222 & D9223	Deep sedation/general anesthesia	First 30 Minutes: $50
		Each Additional 15 Minutes: $0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital or ambulatory surgical center call	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9910	Application of desensitizing medicament	$0
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9944	Occlusal guard - hard appliance, full arch	$50
D9945	Occlusal guard - soft appliance, full arch	$50
D9946	Occlusal guard - hard appliance, partial arch	$50
D9951	Occlusal adjustment - limited	$35
D9952	Occlusal adjustment - complete	$50
	Out of Area Emergency Reimbursement (The Enrollee is reimbursed up to $200 per visit.)	All charges in excess of $200

Appendix B - Orthodontic Treatment

1. General Provisions.

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

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

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

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

e. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services. The Pre-Orthodontic Service Copayments will be credited towards the Orthodontic Service Copayment due if the Enrollee accepts the treatment plan. The Copayment for limited orthodontic treatment may be prorated based on the treatment plan.

f. The General Office Visit Copayment listed in Appendix A is charged at each visit for orthodontic treatment. Services provided in connection with orthodontic treatment are subject to the Service Copayments listed in Appendix A.

2. Pre-Orthodontic Service Copayment.

Initial orthodontic exam: $50
Study models and X-rays: $0
Case presentation: $0

3. Orthodontic Service Copayment.

Comprehensive Orthodontic Service Copayment: $1,500
The following orthodontic procedures are Covered Services under this benefit:
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

Appendix C - Temporomandibular Joint Disorder Treatment

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

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

2. Limitations and Exclusions.

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

Appendix D - Dental Implants

1. Benefits.

a. The dental implant services described in this Appendix D are covered for Enrollees if all of the following requirements are met:
   1) A Participating Provider determines that dental implants are dentally appropriate for the Enrollee.
   2) A Participating Provider prepares the treatment plan for dental implants prior to initiating any implant treatment.
   3) All dental implant services are provided by a Participating Provider or under a referral from a Participating Provider.
   4) The Enrollee follows the treatment plan prescribed by the Participating Provider.
   5) The Enrollee makes payment of amounts due.
   6) The dental implant service is listed as covered in this Appendix D and is not otherwise limited or excluded.

b. **Services After Termination of Benefits.** If the Enrollee's coverage ends before the completion of the dental implant services, the cost of any remaining treatment is the Enrollee's responsibility.

c. **Dental Implant Surgery.** The following dental implant services are covered at **100% up to an annual dental implant benefit maximum of $1,500 per implant**. The annual dental implant benefit maximum is the maximum dollar amount the Plan will cover for benefits for the below dental implant services in a calendar year.

CDT Code and Procedure Description
D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery

2. Limitations. The benefit for dental implants is subject to the following limitations:

a. Benefits for surgical placement of a dental implant is limited to 1 per calendar year
b. Dental implants to replace an existing bridge or existing denture will not be covered, unless 5 years have elapsed since the placement of the bridge or delivery of the denture.

3. Exclusions. The following services are not covered under this benefit for dental implants:

a. Any dental implant services and related services that are not listed as covered on this Appendix D.
b. Bone grafting.
c. Cone beam CT X-rays and tomographic surveys.
d. Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
e. A dental implant that was surgically placed prior to the Enrollee's effective date of coverage under the Plan and has not received final restoration.
f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.
g. Maintenance, repair, replacement, or completion of an existing implant that was started or placed by a Non-Participating Provider without a referral from a Participating Provider.
h. Maintenance, repair, replacement, or completion of an existing implant that was started or placed prior to the effective date of coverage under the Plan.
i. Treatment of a primary or transitional dentition.