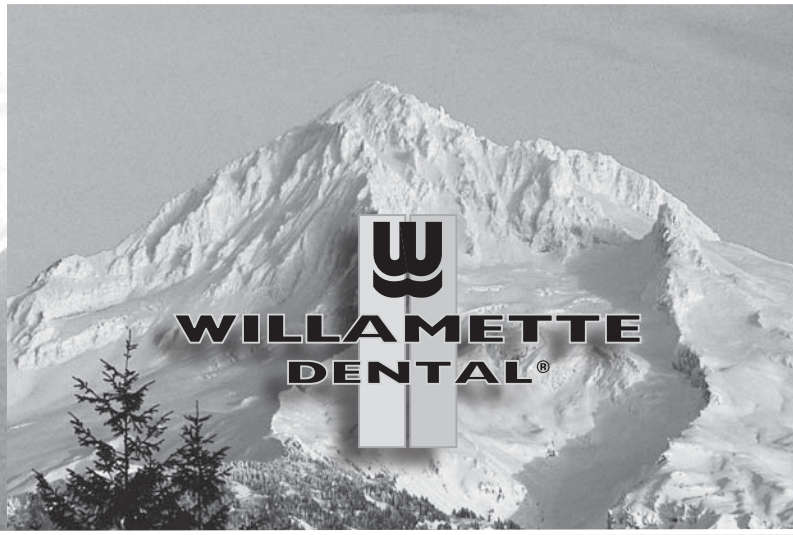
Affordable Quality Dental Care



Willamette Dental Plan

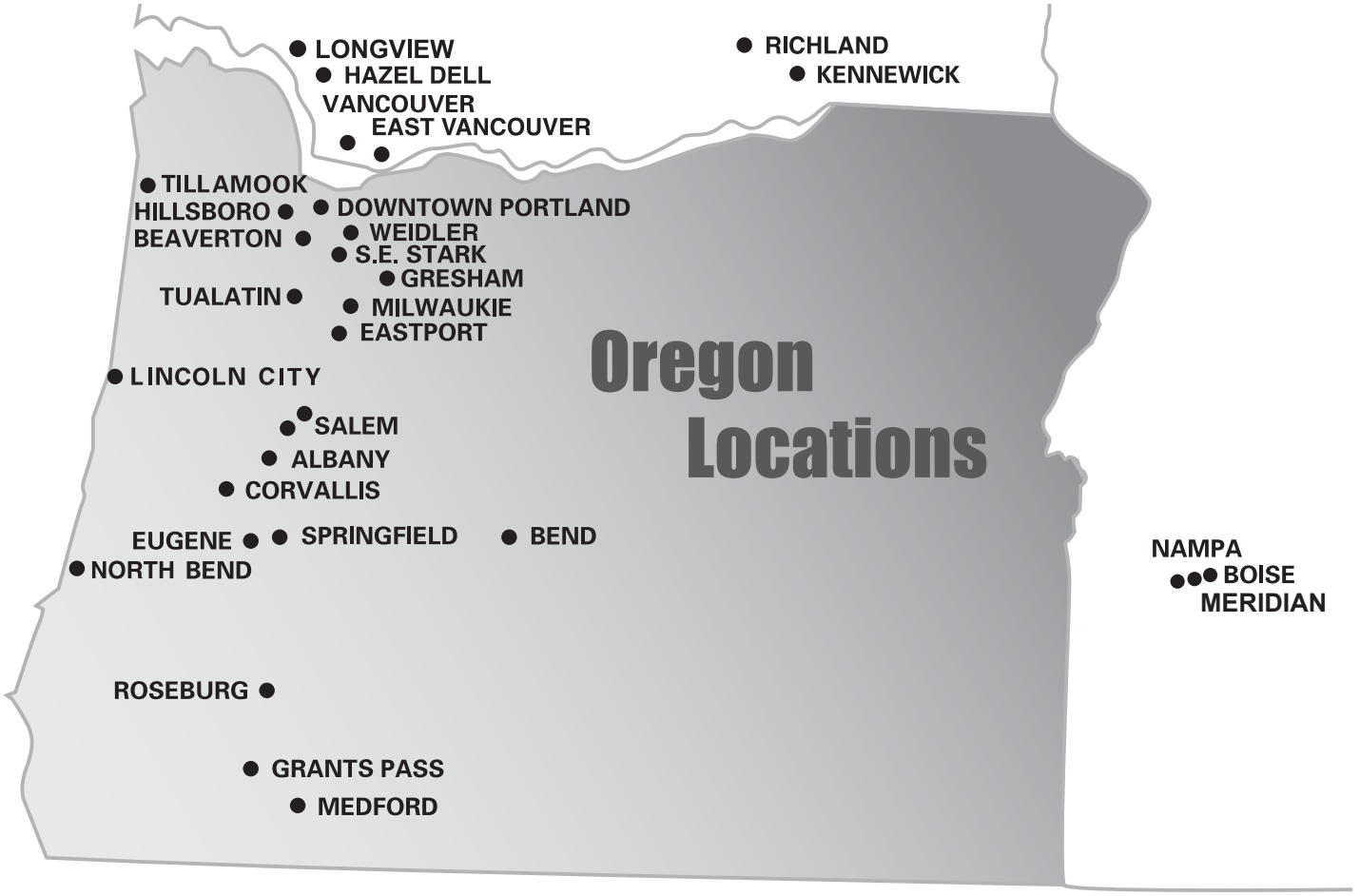
Certificate of Coverage

State of Oregon
Public Employees'
Benefit Board

Dental Certificate
Form No. 002-ORPEBB (11/07)

Effective: January 1, 2008
Group Plan Number: Z-250

WILLAMETTE DENTAL®



Evidence-Based Dentistry With A Focus On Prevention

Appointments or Emergencies

Toll Free ..... (800) 461-8994
Portland Metro Area .....(503) 952-2100

Patient Relations (Customer Service)

Willamette Dental has a full staff of patient relations representatives who will answer any question that you may have about your dental plan or service. You may contact Patient Relations:

Monday - Friday ..... 8 AM to 5 PM PST
Toll Free ..... (800) 460-7644
Portland Metro Area ..... (503) 952-2000
E-mail ..... relations@willamettedental.com
Website ..... www.WillametteDental.com

Willamette Dental Insurance, Inc.

Certificate of Coverage

Contents

Effective: January 1, 2008 • Group Plan Number: Z-250 • Printed: 1/08

A Contract for dental benefits exists between the Group and Willamette Dental Insurance, Inc. unless otherwise terminated in accordance with the Contract. Willamette Dental Insurance, Inc. certifies that the Member will be covered by the terms of that Contract and the provisions of this Certificate of Coverage (also referred to as "Certificate"). If the Member's coverage is modified, Willamette Dental Insurance, Inc. will provide the Group with a revised Certificate, or other notice to be given to Members. Possession of this Certificate does not necessarily mean the Member is covered. A Member is covered only if the requirements set out in this Certificate and terms of the Contract are met.

DEFINITIONS

The following defined terms are used throughout this Certificate:

Benefits means services performed by a provider that are covered under the Contract and explained in this Certificate and any payments by the Company for a Member for services or supplies covered under the Contract and explained in this Certificate .

Calendar Year means January 1 through December 31.

Company means Willamette Dental Insurance, Inc.

Co-pay and **Co-payment** means the dollar amount that will be the Member's responsibility to pay for certain services received under this Certificate

Dependent means a person listed on the Member's enrollment application as a Dependent of the Member, who is eligible for Dependent coverage under the terms of the Contract and explained in this Certificate and Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board), and whose enrollment application for coverage has been accepted by the Company, and for whom the applicable Premium for coverage has been paid.

Dental Emergency means the sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring necessary care to control pain, swelling or bleeding in or around the teeth and gums. Such emergency care must be provided within forty-eight (48) hours following the onset of the emergency and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency care does not include follow up care such as, but not limited to, crowns, root canal therapy, or prosthetic Benefits. For the purpose of Benefit determination, consideration will be given by the Company to the symptoms of the condition and the actions that would have been taken by a prudent person under such circumstances.

Group means the employer (including approved affiliates and subsidiaries) for which coverage under the Contract and explained in this Certificate is approved in writing by the Company.

Group Representative means the employer or a person who has been designated by the Group to act as its plan fiduciary. These duties include, but are not limited to, the ability to remit the Premium to the Company and to give and receive any notices under the Contract or explained in this Certificate.

Investigational Service or Supply means a service or supply (including, but not limited to, equipment, drugs, devices, and other items) that is determined by the Company to meet any one of the following:

Any service or supply classified by the Company as experimental or investigational. The terms experimental and investigational shall mean services or supplies which are under continued scientific testing and research because they have not yet been proven to show a demonstrable benefit for a particular illness, disease or condition, or to be safe and efficacious. The Company, in the Company's sole discretion, shall make all determinations of which services and supplies will be considered to be experimental or investigational. In determining whether services or supplies are experimental or investigational, the Company will consider whether the services or supplies are in general use in the dental community in the State of Oregon, whether the services or supplies are under continued scientific testing and research, whether the services or supplies show a demonstrable benefit for a particular illness, disease or condition, and whether the services or supplies are proven to be safe and efficacious. Upon the Company's receipt of written request therefore, the Company shall provide to a Member all documentation in the Company's possession and used by the Company in connection with determining whether a service or supply is experimental or investigational.

Any service or supply that is on an investigational protocol, unless approved in writing in advance by the Company.

Licensed Dentist means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

Member means an individual member of the Group who is eligible for Member coverage under the terms of the Contract and

Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board), whose enrollment application for coverage has been accepted by the Company, and for whom the applicable Premium for coverage has been paid.

Necessary Service or Supply means that the service or supply meets all of the following criteria as determined by the Participating Dentist:

- It is required to diagnose or treat the Member's condition.
- It is consistent with the symptoms or diagnosis and treatment of the condition.
- It is the most appropriate level of service that is essential to the Member's needs.
- It is not an Investigational Service or Supply.
- It is not primarily for the convenience of the Member or the Participating Provider.

Participating Dentist means a Licensed Dentist who is employed by or is under contract with Willamette Dental Group, P.C., any of its affiliates, or any other Participating Provider, to provide dental services on behalf of the Company to Members according to the terms of this Certificate.

Participating Provider means a dental services provider which has contracted in writing with the Company to accept payment from and to look solely to the Company according to the terms of this Certificate for any dental services rendered to a Member who has previously paid, or on whose behalf prepayment has been made, to the Company for such dental services.

Premium means the total money to be paid to the Company each month as consideration for the Benefits offered by the Contract and explained in this Certificate.

Specialist means a Licensed Dentist who has completed additional training in one or more areas of dental treatment and who provides services to the Member upon referral by the Participating Dentist.

Willamette Dental Group, P.C. means the Oregon corporation which has signed a dental services provider agreement with the Company to act as a Participating Provider for the Company for purposes of providing dental services on behalf of the Company to Members according to the terms of the Contract and explained in this Certificate.

MEMBER AND DEPENDENT ELIGIBILITY AND ENROLLMENT FOR COVERAGE

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

INELIGIBLE PERSONS

Any ineligible person enrolled under this Certificate will not be entitled to Benefits. The Company shall be entitled to repayment from the ineligible person, or from the Member for the cost of Benefits provided during the period of ineligibility in excess of the amounts received by the Company for the ineligible person for that period. The total amount of repayment to which the Company is entitled from all parties shall not exceed the difference between the cost of Benefits provided during the period of ineligibility and the amounts received by the Company for the ineligible person for that period.

FALSE STATEMENTS

If the Member or the Group Representative or anyone acting on behalf of either of them makes a false statement in the enrollment application or eligibility records, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Company, or otherwise misleads the Company into providing Benefits it would not otherwise have provided, the Company shall be entitled to recover its damages from the Member, from the Group, from any other person responsible for misleading the Company, and from the person for whom the Benefits were provided.

WHEN COVERAGE ENDS

1) Coverage ends on the earliest of the following dates:

a. For any Member or Dependent enrolled under the Contract, coverage ends on the date the Contract terminates.
b. If monthly Premium payments for coverage are not made, coverage ends for the Member and Dependents on the last day of the month for which the last full Premium was paid.
c. At the end of the month for which eligibility ceases.
d. On the date of written notice, if there is legal cause.

e. The last day of the month following at least thirty (30) days advance written notice to a Member that the Participating Provider has documented an inability to establish or maintain a Member/Provider relationship between the Member and a Participating Dentist at locations reasonably accessible to the Member.

2) Coverage may be continued in certain circumstances (unless it ends under a. through e. above) in accordance with the Oregon Administrative Rules, Chapter 101(Public Employees' Benefit Board).

Reinstatement - If coverage terminates because a Member ceases to be a Member, reinstatement may be available in accordance with Oregon Administrative Rules, Chapter 101.

EXCLUSIONS

No Benefits will be provided for the following:

Conscious sedation/general anesthesia.

Any condition resulting from military service or declared or undeclared war.

Any injuries sustained while practicing for or competing in a professional or semiprofessional athletic contest. Semiprofessional athletic contest means an athletic activity for gain or pay that requires an unusually high level of skill and substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full time occupation.

Bleaching of a tooth.

Endodontics, bridges, crowns or other service or prosthetic devices requiring multiple treatment dates or fittings if treatment was started or ordered prior to the Member's or Dependent's effective date under this Certificate or if the item was installed or delivered more than sixty (60) days after the Member's or Dependent's coverage under the Contract has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within sixty (60) days after termination.

Charges or services or supplies provided by any person other than a Licensed Dentist, licensed denturist, or licensed hygienist.

Charges or services or supplies that would not have been made or that the Member or Dependent would have had no obligation to pay in the absence of the Contract.

Charges or services or supplies provided to comply with Occupational Safety and Health Administration requirements.

Full mouth reconstruction. Full-mouth Reconstruction is the extensive restoration of the entire mouth with crowns, bridges or implants to restore natural function.

Cosmetic dentistry or surgery.

Dental implants, or implant supported prosthetics, unless specifically provided in a rider to this Certificate.

Excision of a tumor, biopsy of soft or hard tissue, removal of a cyst, or exostosis.

Dental services started prior to the date the person became eligible for services under the Contract.

Extraction of permanent teeth for tooth guidance procedures, procedures for tooth movement, regardless of purpose, correction of malocclusion, preventive orthodontic procedures, or other orthodontic treatment, unless specifically provided in a rider to this Certificate.

Habit breaking or stress breaking appliances.

Hospital or other facility care for dental procedures, including physician services for hospital treatment. Services of a Licensed Dentist will be provided in a hospital or other facility only when all of the following requirements are met, subject to the hospital visit Co-payment specified in Exhibit A to this Certificate: A) A hospital setting must be medically necessary. B) The services must be authorized, in writing, in advance by a Participating Dentist.

Intentionally self inflicted injuries. The fact that a person may be under the influence of any chemical substance shall not be considered as a limitation on the ability to form the intent specified in this section.

Investigational Services or Supplies, as defined in the Definitions section of this Certificate.

Materials not approved by the American Dental Association.

For occupational injury or disease (including any arising out of self employment).

Occlusal guards.

Personalized restoration, precision attachments, and special techniques.

Prescription drugs, medications or supplies.

Repair or replacement of lost, stolen or broken items.

Replacement of an existing denture, crown, or bridge less than five (5) years after the date of the most recent placement.

Replacement of sound restorations.

Services or supplies that are not listed as covered in Exhibit A to this Certificate.

Services to the extent that they are not necessary for treatment of a dental injury or disease or are not recommended and approved by the Licensed Dentist attending the Member or Dependent.

To the extent that Benefits are payable, or would have been payable in the absence of this Certificate, under Part A or Part B of the Federal Medicare Act, Pub. L. No. 89 97 (July 30, 1965) and amendments thereto, except as otherwise required by law.

To the extent that coverage is available under any federal, state, or other governmental program if application is duly made therefore, except where required by law for cases of emergency.

Services for Temporomandibular Joint Disorders.

Transseptal fiberotomy.

Veneers, composite surfaces on posterior teeth.

Splints, nightguards, and other appliances used to increase vertical dimension and restore bite.

Orthognathic surgery.

Services or supplies provided to correct congenital or developmental malformations including, but not limited to, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypolasis, ectodermal dysplasia and fluorosis (discoloration of teeth).

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the dental 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 dental care benefits isseparate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating

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

D. Allowable Expense is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

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

(2) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

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

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

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

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

Order Of Benefit Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the

order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) 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 plan years commencing after the Plan is given notice of the court decree;

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

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

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

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

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

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan. Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

Effect On The Benefits Of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

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

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

Facility Of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

Right Of Recovery
If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Important Note: If this Coordination of Benefits provision conflicts with Oregon Administrative Rules 101-030, the Oregon Administrative Rules will govern.

DENTAL COVERAGE

Agreement to Provide Benefits
The Company agrees to provide to the Member and Dependent, as determined necessary by and through the Participating Dentists and while the Contract is in force, the services specified in Exhibit A of the Certificate. All Benefits are subject to the Co-payments stated in Exhibit A and to all other terms stated in this Certificate.

The Member and Dependent must receive services from a Participating Dentist for services to be covered under the Contract, except as otherwise specifically explained in this Certificate. The Participating Dentists who are providing the services covered under the Contract and explained in this Certificate agree that they will accept fees in the amount established by the Company as full payment for their services, except for the Member's or Dependent's Co-payment responsibility as explained in this Certificate. The Participating Dentists agree that their charges to the Member or Dependent will not exceed the Co-payment amounts specified in Exhibit A to this Certificate.

1. The Company will make available to the Group Representative a list of the Participating Provider offices at which the Participating Dentists offer services. The Company reserves the right to change the list without notice, but a current list shall be maintained at the principal office of the Company for the Members review during regular business hours.

2. The services of a Specialist will only be covered upon referral by a Participating Dentist. The Member or Dependent will be responsible for charges by the Specialist for procedures other than those specifically authorized by the Participating Dentist.

Necessary Dental Care – Subject to, and consistent with the Benefits described in this Certificate, Benefits will only be provided for Necessary Services or Supplies, and the Participating Provider will be the only judge of the necessity of any Service or Supply.

Visit Co-payment – The Member will be responsible to pay a Co-payment as Specified in Exhibit A of this Certificate for each visit to a Participating Dentist at the time of each visit.

Service Co-payment – In addition to the visit Co-payment, some procedures require a service Co-payment as specified in Exhibit A to this Certificate. All service Co-payments are paid directly to the Participating Dentist at the time of Service.

EMERGENCY COVERAGE

Coverage for a Dental Emergency will be provided twenty-four (24) hours a day, three hundred sixty-five (365) days a year. When emergency services are received during office hours by a Participating Dentist at a Participating Provider office, the Member or Dependent will be responsible for the standard office visit Co-payment as specified in Exhibit A to this Certificate. When emergency services are received after hours by a Participating Dentist at a Participating Provider office, the Member or Dependent will be responsible for the standard office visit Co-payment and an additional emergency treatment after hours Co-payment as specified in Exhibit A to this Certificate. Office hours shall mean 7:00 a.m. to 6:00 p.m., Monday through Saturday (excluding all nationally recognized holidays) and after hours shall mean all other hours and days in a calendar week.

In the event of a Dental Emergency that requires the services of a non-Participating Dentist located outside of a fifty (50) mile radius of any Participating Provider office, the Company will reimburse to the Member up to $150 for the cost of the services provided by the non-participating dentist to the extent that such services would have been available under this Certificate if the Member had used a Participating Dentist. If, in the event of a Dental Emergency, the Member uses a non-participating dentist, claims for Benefits explained under this Certificate must be presented to the Company in writing. When a claim form is submitted, it must be completely filled out and signed by the Member and the non-participating dentist and must be accompanied by an itemized statement from the dentist for his or her services. The Company shall have the right to request additional information from the dentist needed to process the claim, including X rays. No Benefits or reimbursement will be provided unless the requested information is received. All claims must be submitted within one (1) year of the date of service.

GRIEVANCE PROCEDURES

If a Member has a grievance against the Company, or the Company has notified the Member in writing that a benefit or reimbursement for emergency care has been denied, the following will occur:

1. The Company will review the Member's grievance and will notify the Member in writing of the decision within thirty (30) days unless special circumstances result in a delay.

2. If the Company is unable to make a decision within thirty (30) days due to circumstances beyond its control, the Company will provide notice to the Member indicating that an extension of up to fifteen (15) additional days is necessary to complete the review process.

3. If the Company requests additional information, the Member will have forty-five (45) days to provide the information. If the Member fails to provide the information within forty-five (45) days, the Company may decide the claim based on the information the Company has already received.

4. The Company shall provide written notification of an adverse determination and the right to appeal to the Member or authorized representative. If all or part of a Member's claim is denied, the Member will receive a written notice of denial containing:
A) The reason for the decision. B) Reference to the parts of this Certificate on which the decision is based. C) Reference to any internal rule or guideline relied upon in making the decision along with the Member's right to receive a copy of these guidelines, free of charge, upon request. D) A statement that the Member may request an explanation of the scientific or clinical judgment the Company relied upon to exclude expenses that are experimental or investigational, or are necessary or accepted according to accepted standards of dental practice. E) The Member or authorized representative may review pertinent documents, records and other information relevant to the claim.

5. The Member, or authorized representative, may request an appeal of the adverse determination and submit grievances and comments to the Company's Member Relations Department within one hundred eighty (180) days after receiving notice of the adverse determination.

6. The Member should state the reason for the appeal and may submit written comments, documents, records or any other information related to the claim.

7. The person conducting the appeal review will be someone other than the person who denied the claim, and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole, or in part, on a clinical judgment including determinations with regard to whether the service was considered experimental, investigational, and/or not dentally necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. The appeal review will include any written comments or other items the Member submits to support their claim.

8. If the Company denies any part of the Member's appeal on review, the Member will receive a written notice of denial containing:
A) The reason for the decision. B) Reference to the parts of this Certificate on which the decision is based. C) Reference to any

internal rule or guideline, free of charge, upon request. D) Information containing the Member's right to receive, free of charge, copies of non-privileged documents and records relevant to the Member's claim. E) A statement that the Member may request an explanation of the scientific or clinical judgment the Company relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice. F) Information concerning the Member's right to bring a civil action.

Note: The Member or Dependent also has the right to file a dental coverage complaint with the Oregon Insurance Division at the following address: Consumer Advocacy Unit, Oregon Insurance Division, Consumer Advocacy Unit, 350 Winter St. NE, Room 440, P.O. Box 14480, Salem, OR 97309-0405. Web site; insurance.oregon.gov. E-mail; ins.cp@state.or.us. Telephone; (503) 947-7984 or toll-free at (888) 877-4894.

SUBROGATION

The Benefits of this Certificate, as determined by the Company, will be available to a Member or Dependent who is injured by another party, subject to the exclusions and limitations of this Certificate. Subject to the limitations, if the Company provides Benefits for the treatment of an injury, whether or not caused by another party, the Company shall: A) Be subrogated to the right of the Member or Dependent or the Member's or Dependent's representative to recover compensation for the injury; and B) Have a security interest in any damage recoveries to the extent of all payments made by the Company.

The Member or Dependent or the Member or Dependent's representative shall: A) Give the Company, in writing, the name and address of the party who caused the injury, the facts surrounding the occurrence of the injury, and any other information reasonably necessary to protect the Company's subrogation rights; and B) If the injury was caused by another party, submit the bills relating to the injury to the other party's liability insurer when the Member knows that the other party has liability insurance and knows or can reasonable ascertain the identity and address of such insurer.

The Member or Dependent or the Member or Dependent's representative shall cooperate fully with the Company in recovering the amount the Company has paid, including giving prior written notice to the Company of any intended settlement. Subject to the limitations specified in this Certificate, the Member or Dependent shall reimburse the Company for its subrogated interest, without reduction for any attorney's fees or costs incurred, except that where the services of a Member or Dependent's attorney are necessary and beneficial to the Company, the Company's subrogation interest shall be reduced by a proportionate share of the attorney's fees.

COLLECTION BY MEMBER OR MEMBER'S REPRESENTATIVE

If a claim is paid, a settlement is made, or a judgment is recovered in connection with the injury, the Company's subrogation rights shall be limited to the excess over the amount necessary to fully compensate the Member or Dependent for the loss sustained.

LIMITATIONS ON LIABILITY

The liability of the Company to the Member or Dependent shall in any event be limited to the amounts as specified for the services defined in this Certificate, and shall not include any liability for any consequential damages, including without limitation, damages for pain and suffering, general damages, statutory damages, or attorney's fees.

WORKER'S COMPENSATION

The Contract or this Certificate do not replace or affect the requirement that an employer provide worker's compensation insurance. Benefits for treatment of a condition arising out of or in the course of employment or self-employment for wages or profit are excluded under this Certificate to the extent the Member or Dependent has claimed or is entitled to claim workers' compensation insurance coverage for the treatment of such condition.

TERMINATION OF BENEFITS

Termination for Member or Dependent Coverage Except as otherwise specified in the COBRA section below, coverage under the Contract shall terminate for a Member or Dependent immediately on the earliest of the following:

1) On the date the entire Contract is terminated;
2) At the end of the last month for which timely payment is received, if the Premium is not received when due or within any grace period as specified in the Contract;
3) At the end of the month during which eligibility ceases;
4) On the date of written notice, if there is legal cause for termination;

5) The last day of the month following at least thirty (30) days advance written notice that the Participating Dentist has documented good cause for termination, such as an inability to establish or maintain a patient/provider relationship between the Member or Dependent and a Participating Dentist at locations reasonably accessible to the Member;
6) If coverage under the Contract terminates for a Member, it will also terminate for the Member's Dependents on the effective date of the termination for the Member.

COBRA CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), gives qualified beneficiaries the right to elect COBRA continuation after Group coverage ends because of a qualifying event. The following provision applies only to Groups that normally employ twenty (20) or more employees on a typical business day during the previous Calendar Year and are required by federal law to comply with COBRA. A qualified beneficiary means a Member or a covered Dependent of a Member (which includes a covered spouse and covered dependent child of a Member).

A. A qualifying event occurs when:

1) The Member dies;
2) The Member's employment terminates for reasons other than gross misconduct;
3) The Member's work hours fall below the minimum number required;
4) The Member becomes divorced or legally separated from a spouse;
5) The Member becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
6) The child of a Member ceases to be a Dependent; or
7) The Group files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Group and is covered on the date the petition is filed.
8) The Member or Dependent meet the requirements of the definition of "triggering event" under Oregon Administrative Rule, 101-030-005.

B. Electing COBRA Continuation:
Each qualified beneficiary has the right to elect to continue coverage that was in effect on the day before the qualifying event. The qualified beneficiary must apply in writing within sixty (60) days of the later of:

1) The date on which coverage would otherwise end; and
2) The date on which the Benefit Help Solutions gave the qualified beneficiary notice of the right to COBRA continuation;

C. Notice Requirements:

1) When the Member becomes covered, the Benefit Help Solutions must inform the Member and spouse in writing of the right to COBRA continuation.
2) The Group must give Benefit Help Solutions written notice within thirty (30) days of a qualifying event as described in items A.1, A.2, A.3, A.5 and A.7 above.
3) Within fourteen (14) days of receipt of the Group's notice, Benefit Help Solutions must notify each qualified beneficiary in writing of the right to elect COBRA continuation.
4) The qualified beneficiary must notify Benefit Help Solutions in writing within sixty (60) days of a qualifying event described in items A.4 and A.6 above.
5) Each qualified beneficiary who, within the first sixty (60) days of COBRA continuation due to a qualifying event described in items A.2 and A.3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of a qualifying event as described in items A.2 and A.3 above must notify Benefit Help Solutions in writing within sixty (60) days after the date disability is determined. If the qualified beneficiary ceases to be disabled, the qualified beneficiary must notify Benefit Help Solutions in writing within thirty (30) days of the final determination date.

Failure by the Member to make timely election or by the Benefit Help Solutions to provide timely notification to the Company will constitute a waiver of the individual's right to continuation coverage under the Contract. Failure to provide timely notices may not, in all cases, terminate an employer's obligation to provide continuation coverage; however, such failure will eliminate any obligation of the Company to provide continuation coverage under the Contract. (See item G. Plan Contact Information below for more information.)

D. Premium Requirements:
Coverage continued under this provision will be retroactive to the date coverage would have ended because of a qualifying event. The qualified beneficiary must pay the initial required Premium not later than forty-five (45) days after electing COBRA continuation, and a monthly Premium on or before the Premium due date thereafter.

E. The COBRA contribution rate is a percentage of the contribution rate currently in effect on each due date. The percentage is as follows:

1) 18-Month COBRA Continuation – Each qualified beneficiary may continue coverage for up to eighteen (18) months after the date of a qualifying event as described in items A.2 and A.3 above. The COBRA contribution percentage is 102%.
2) 29-Month COBRA Continuation – Each qualified beneficiary who, within the first sixty (60) days of COBRA continuation due to qualifying event as described in items A.2 and A.3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of a qualifying event as described in items A.2 and A.3 above, may continue coverage for up to twenty-nine (29) months after the date of the qualifying event. All Members in the qualified beneficiary's family may also continue coverage for up to twenty-nine (29) months. The COBRA contribution percentage is 102% during the first eighteen (18) months and 150% during the next eleven (11) months.
3) 36-Month COBRA Continuation – A Dependent (which includes a spouse or dependent of the Member) may continue coverage for up to thirty-six (36) months after the date of a qualifying event as described in items A.1, A.4, A.5 and A.6 above. The COBRA contribution percentage is 102%.
4) COBRA Continuation For Certain Bankruptcy Proceedings - If the qualifying event is the event described in item 7, above, the COBRA continuation period for a retiree or retiree's spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving spouse and Dependent children is 36 months from the date of the retiree's death.
   Note: The total period of COBRA continuation available for qualifying events described in items A.1 through A.3 above will not exceed thirty-six (36) months.

F. COBRA continuation ends on the earliest of:

1) The date the Contract terminates;
2) The date the last period ends for which a required contribution was made;
3) Thirty (30) days after the date the last period ends for which a required Premium payment was made;
4) The last day of the COBRA continuation period;
5) The date (after the date of the qualified beneficiary's COBRA election) the qualified beneficiary first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act; or
6) The first date (after the date of the qualified beneficiary's COBRA election) on which the qualified beneficiary is: (i) covered under another group dental plan, and (ii) not subject to any preexisting condition limitation under such other group dental plan.

G. Plan Contact Information

This COBRA Continuation section of the qualified beneficiary's Certificate of Coverage is a summary of his or her potential options under COBRA. If he or she a) has further questions concerning the Plan or the COBRA continuation coverage; or b) needs to obtain notices or needs help completing information to apply for COBRA continuation coverage, he or should contact Benefit Help Solutions.

If qualified beneficiary has any questions about this statement or his or her rights under COBRA and other laws affecting group health plans, he or she may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in his or her area or visit the EBSA website at www.dol.gov/ebsa (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Cessation of Benefits Upon Contract Termination

No person shall have or acquire a vested right to receive Benefits after the date this Contract is terminated. Unless otherwise specified in this Contract, termination of this Contract as to an individual Member or Dependent for any reason shall completely end all obligations of the Company to provide the Member or Dependent with Benefits including, but not limited to, services or supplies received after the date of termination whether or not the Member or Dependent may then be receiving treatment, unless otherwise specified, or may thereafter be in need of treatment, for any dental condition incurred or treated before or while this Contract was in effect.

TRADE ACT OF 2002

This COBRA provision applies only to Members who have lost their jobs or had a reduction in hours as a result of import competition or shifts of production to other countries.

A. Second Election Period for Certain Trade-Displaced Individuals

Certain covered Members who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Covered Members who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Members) must satisfy each of the following requirements:

1) They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
2) They must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and
3) They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

The special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which a TAA Eligible Member began receiving a trade readjustment allowance (or would have become eligible for such an allowance but for the requirement to exhaust unemployment compensation) or began receiving alternative trade adjustment assistance, but only if the election is made within six months after the initial loss of group health plan coverage that occurred in connection with the TAA Eligible Member's termination of employment.

B. Duration of COBRA Coverage Elected During the Special Second Election Period
COBRA coverage elected during the special second election period is not retroactive – coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

GENERAL PROVISIONS

Allocation of Authority
Except for those functions which the Contract specifically reserves to the Group, the Company will have full and exclusive authority to control and manage the Contract, to administer claims, and to interpret the Contract and resolve all questions arising in the administration, interpretation, and application of the Contract. The Company's authority includes, but is not limited to: (i) the right to resolve all matters when a review has been requested; (ii) the right to establish and enforce rules and procedures for the administration of the Contract and any claim under it; (iii) the right to determine eligibility for insurance, entitlements to Benefits, and amount of Benefits payable; and (iiii) sufficiency and the amount of information the Company may reasonably require to determine (i), (ii) or (iii) above. Subject to the review procedures of the Contract, any decision made by the Company in the exercise of the Company's authority is conclusive and binding.

Rights Not Transferable
The Benefits of the Contract are offered personally to the Member and any covered Dependents and are not transferable.

Headings
The headings of articles, sections and paragraphs are used solely for convenience of reference and are not a part of the Contract or guides to the interpretation hereof.

State Law and Forum
The Contract is entered into and delivered in the State of Oregon, and Oregon law will govern the interpretation of its provisions.

Representations are not Warranties
In the absence of fraud, all statements made by applicants, the Group or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void the insurance or reduce Benefits unless contained in a written instrument signed by the Group or the insured person, a copy of which has been furnished to the Group or to the person or the beneficiary of the person.

Clerical Error
Clerical error by the Company, the Group, or Plan Administrator will not: 1) Cause a Member or Dependent to become covered under the Contract; 2) Invalidate coverage under the Contract otherwise validly in force; or 3) Continue coverage under the Contract otherwise validly terminated.

EXHIBIT A
SCHEDULE OF COVERED SERVICES AND CO-PAYMENTS

ADA Code	Procedure	Co-payment
1. Office Visit Charge		None
2. Diagnostic and Preventative Services		
00120	Periodic oral evaluation	None
00140	Limited oral evaluation-emergency	None
00150	Comprehensive oral evaluation	None
00210	Complete series x-rays	None
00220	Periapical-first film	None
00230	Intraoral - each additional film	None
00240	Intraoral - occlusal film	None
00250	Extraoral - first film	None
00260	Extraoral - each additional	None
00270	Bitewings - single film	None
00272	Bitewings – two films	None
00274	Bitewings-four films	None
00330	Panoramic x-rays	None
01110	Teeth cleaning (prophylaxis) adult	None
01120	Teeth cleaning (prophylaxis) child	None
01203	Topical fluoride-child	None
01204	Topical fluoride-adult	None
01310	Diet modification	None
01320	Tobacco counseling	None
01330	Oral Hygiene Instruction	None
01351	Sealant/tooth	None
00415	Microscopic evaluation	None
00460	Pulp vitality test	None
00510	Histopathologic examination	None
3. Space Maintainers		
01510	Space Maintainer – unilateral-fixed	None
01515	Space Maintainer – bilateral-fixed	None
01520	Space Maintainer – unilateral-removable	None
01525	Space Maintainer – bilateral removable	None
01550	Space Maintainer – recement	None
4. Restorative Dentistry		
a. Amalgam Restorations – Primary Teeth		
02110	Fillings – 1 surface	None
02120	Fillings – 2 surfaces	None
02130	Fillings – 3 surfaces	None
02131	Fillings – 4 or more surfaces	None
b. Amalgam Restorations – Permanent Teeth		
02140	Filings – 1 surface	None
02150	Fillings – 2 surfaces	None
02160	Fillings – 3 surfaces	None
02161	Fillings – 4 or more surfaces	None
02210	Silicate – cement per restoration	None
02951	Pin retention – per tooth, in addition to restoration	None
02940	Sedative filling – temporary	None
c. Resin Restorations		
02330	Resin-1 surface (anterior only)	None
02331	Resin-2 surfaces (anterior only)	None
02332	Resin-3 surfaces (anterior only)	None
02335	Resin-4 surfaces (anterior only)	None
02336	Crown - resin primary anterior	None
02950	Core buildup, including any pins	None
02380	Resin-one surface (primary posterior only)	None
02381	Resin-two surfaces (primary posterior only)	None
02382	Resin-three surfaces (primary posterior only)	None
d. Inlay/Onlay (cast restorations)		
02510	Inlay-gold 1 surface	$190
02520	Inlay-gold 2 surfaces	$190
02530	Inlay-gold 3 or more surfaces	$190
02543	Onlay-gold 3 surfaces	$190
02544	Onlay-gold 4 or more surfaces	$190
02610	Inlay-porcelain/ceramic 1 surface	$190
02620	Inlay-porcelain/ceramic 2 surfaces	$190
02630	Inlay-porcelain/ceramic 3 surfaces	$190
02644	Onlay-porcelain 4 or more surfaces	$190
02910	Recement inlay	None
5. Crowns		
02710	Crown-resin laboratory	$190
02740	Crown-porcelain/ceramic (anterior only)	$190
02750	Crown-porcelain/metal	$190
02790	Full cast crown – gold	$190
02810	¾ crown – gold	$190
02920	Recement crown	None
02970	Temporary crown for fractured tooth	None
02930	Stainless Steel crown-primary	None
02931	Stainless Steel crown-permanent	None
02932	Crown-prefabricated resin	None
02933	Crown-prefabricated stainless steel w/resin window	None
02954	Prefabricated dowel post & core	None
02955	Post removal (no endo therapy)	None
02970	Temporary crown (fractured tooth)	None
02980	Repair crown	None
6. Endodontics		
03110	Pulp cap-direct except final restoration	None
03120	Pulp cap-indirect	None
03220	Pulpotomy	None
03230	Pulpal therapy – primary anterior	None
03240	Pulpal therapy – primary posterior	None
03310	Root canal therapy – anterior	None
03320	Root canal therapy – bicuspid	None
03330	Root canal therapy – molar	None
03346	Retreatment – anterior	None
03347	Retreatment – bicuspid	None
03348	Retreatment – molar	None
03351	Apexification – initial visit	None
03352	Apexification – interim visit	None
03353	Apexification – final visit	None
03410	Apicoectomy – anterior	None
03421	Apicoectomy – bicuspid 1st root	None
03425	Apicoectomy – molar 1st root	None
03426	Apicoectomy – each additional root	None
03430	Retrograde filling – per root	None
03450	Root amputation per tooth	None
03920	Hemisection	None
03950	Canal prep-preform dowel/post	None
7. Periodontics		
04210	Gingivectomy or gingivoplasty – per quadrant	None
04211	Gingivectomy – per tooth	None
04220	Gingival curettage – per quadrant	None
04240	Gingival flap inclusion - per quadrant	None

ADA Code	Procedure	Co-payment
04249	Crown lengthening hard tissue	None
04250	Mucogingival surgery – per quadrant	None
04260	Osseous surgery – per quadrant	$190
04263	Bone replacement graft – 1st site	None
04264	Bone graft – each additional site	None
04270	Pedicle soft tissue graft procedure	None
04271	Free soft tissue graft procedure	None
04273	Subepithelial connective graft	None
04274	Distal wedge procedure	None
04341	Periodontic scale & root plane – per quadrant	None
04355	Preliminary full-mouth debridement	None
04381	Antimicrobial irrigation	None
04910	Periodontic maintenence following therapy	None
8. Prosthetics		
05110	Complete (upper denture)	$190
05120	Complete (lower denture)	$190
05130	Immediate (upper denture)	$190
05140	Immediate (lower denture)	$190
05213	Partial (upper denture)	$190
05281	Partial-removable unilateral	$190
05410	Adjustment – complete denture, upper	None
05411	Adjustment – complete denture, lower	None
05421	Adjustment – partial denture, upper	None
05422	Adjustment – partial denture, lower	None
05510	Repair broken denture no teeth damaged	None
05520	Repair denture replace missing or broken teeth (each tooth)	None
05620	Repair partial cast framework	None
05630	Repair or replace partial clasp	None
05640	Replace teeth – partial per tooth	None
05650	Add tooth to existing partial	None
05660	Add clasp to existing partial	None
05710	Rebase complete upper denture	None
05711	Rebase complete lower denture	None
05720	Rebase upper partial	None
05721	Rebase lower partial	None
05730	Reline complete upper denture (chairside)	None
05731	Reline complete lower denture (chairside)	None
05740	Reline upper partial (chairside)	None
05741	Reline lower partial (chairside)	None
05750	Reline upper denture - lab	None
05751	Reline lower denture – lab	None
05760	Reline upper partial – lab	None
05761	Reline lower partial – lab	None
05810	Interim denture – upper	$95
05811	Interim denture – lower	$95
05820	Interim partial – upper	$95
05821	Interim partial – lower	$95
05850	Tissue conditioning – upper	None
05851	Tissue conditioning – lower	None
05860	Overdenture – complete	$190
05861	Overdenture – partial	$190
05986	Fluoride gel custom trays	None
9. Pontics (Bridge)		
06210	Pontic, cast (per tooth)	$190
06240	Pontic (per tooth); porcelain/metal	$190
06241	Pontic (per tooth) maryland bridge	$190
06545	Maryland bridge abutment	$190
06720	Crown-resin/metal abutment	$190
06750	Crown-porcelain metal abutment	$190
06780	Crown ¾ cast metal abutment	$190

ADA Code	Procedure	Co-payment
06790	Crown – full gold abutment	$190
06930	Recement bridge	None
06972	Prefabricated post/core in addition to bridge	None
06973	Core build-up w/wo pins	None
06975	Coping – metal	None
06980	Bridge repair	None
10. Oral Surgery		
07110	Routine extraction – single tooth	None
07120	Each additional tooth – routine extraction	None
07130	Root removal	None
07210	Surgical extraction – erupted	None
07220	Removal of impacted tooth – soft tissue	None
07230	Removal of impacted tooth – partial bony	None
07240	Removal of impacted tooth – complete bony	None
07241	Removal of impacted tooth – complete bony with complications	None
07250	Surgical removal residual root	None
07260	Oroantral fistula closure	None
07270	Tooth re-implantation	None
07291	Transseptal fiberotomy	None
07310	Alveoloplasty w/exposure-per quadrant	None
07320	Alveoloplasty w/o exposure-per quadrant	None
07340	Vestibuloplasty	None
07350	Vestibuloplasty – more complex	None
07470	Removal of exostosis	None
07960	Frenectomy	None
07281	Surgical exposure to aid eruption	None
07510	I & D intraoral soft tissue	None
07520	I & D extraoral soft tissue	None
07530	Remove foreign body – soft tissue	None
07540	Remove foreign body – hard tissue	None
07670	Stabilization splint-alveolus	None
07910	Suture small wound up to 5 cm	None
07911	Complicated suture up to 5 cm	None
07940	Osteoplasty	None
07970	Excision hyperplastic tissue	None
07971	Excision of pericoronal flap	None
11. Anesthesia		
09110	Palliative (emergency) minor	None
09230	Nitrous Oxide (per visit)	Not covered
09220	General Anesthesia -1st 30 minutes	Not covered
09221	General Anesthesia - Each Additional 15 minutes	Not covered
12. Miscellaneous		
09310	Consultation – per session	None
09910	Desensitizing medicaments	None
09430	Observation visit	None
09440	Emergency treatment – after office hours	None
09951	Occlusal adjustment - simple	None
09952	Occlusal adjustment - complete	None
09970	Enamel microabrasion	None
09420	Hospital Visit – exam (service co-paymentss still apply)	$125
Cancellation of appointment without 24 hours notice		$20
Out of area emergency reimbursement		$150
13. Exclusions	See Exclusions section of your Certificate.	

ORTHODONTIC SERVICES RIDER

Orthodontic Services as described below will be provided by a Participating Dentist or a Specialist when a treatment plan is prepared by a Participating Dentist prior to rendering services. The treatment plan is based on an examination that must take place while the Member or Dependent is covered under the Contract and the examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care. If a Member or Dependent's orthodontic treatment was started prior to enrolling for coverage under the Contract, orthodontic treatment will be pro-rated according to the extent of Orthodontic Services provided by the Company to complete the treatment plan.

Services connected with orthodontic treatment will be provided subject to the service Co-payments listed below and the applicable service Co-payments listed in Exhibit A to the Certificate. There are no limitations to the length of orthodontic treatment provided the Member or Dependent remains covered under the Contract. Once active treatment ends, there will be no additional orthodontic service Co-payments for three (3) years provided that the post-treatment plan is followed and appointments are kept.

No Benefits will be provided for appliances being replaced (such as headgear and retainers) or for Benefits provided prior to rendering such treatment. If coverage under the Contract terminates prior to completion of orthodontic treatment, there may be additional charges for Orthodontic Services rendered if treatment continues after the termination or change in the Member or Dependent's dental coverage. Continuing orthodontic treatment will be pro-rated based on fee-for-service rates. If orthodontic treatment Benefits terminate before the end of the prescribed treatment period, Benefits will continue through the end of the month in which the orthodontic coverage was terminated.

Pre-Orthodontic Service Co-Payment
The Member or Dependent will be responsible to pay the Co-payments listed below for Pre-Orthodontic Services provided:

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

The Pre-Orthodontic Co-payments will be deducted from the Orthodontic Service Co-payments listed below.

Orthodontic Service Co-Payment
The Member or Dependent will be responsible to pay the Co-payments listed below for Orthodontic Services provided:

Co-payment for all levels of comprehensive Orthodontic Services: $1,200

Co-payment for limited Orthodontic Services will be pro-rated based on the treatment rendered, provided that such Co-payment shall not exceed the Co-payment for comprehensive Orthodontic Services shown above.

Orthodontic Services Provided
The following are the Orthodontic Services provided pursuant to this Orthodontic Services Rider:

ADA Code	Procedure
08020	Limited Orthodontic Treatment Transitional (Mixed dentition)
08030	Limited Orthodontic Treatment Adolescent (Permanent Dentition & Growing)
08040	Limited Orthodontic Treatment Adult (Permanent Dentition – not growing)
08060	Interceptive Orthodontic Treatment/Transitional
08070	Comprehensive Orthodontic Treatment Transitional (Mixed Dentition)
08080	Comprehensive Orthodontic Treatment Adolescent (Permanent Dentition & Growing
08090	Comprehensive Orthodontic Treatment Adult (Permanent Dentition – not growing)

IMPLANT SERVICES RIDER

Implant Services as described below will be provided by a Participating Dentist or a Specialist when a treatment plan is prepared by a Participating Dentist prior to rendering services. The treatment plan is based on an examination that must take place while the Member or Dependent is covered under the Contract. Services connected with implant treatment will be provided subject to the service Co-payments listed below, and any applicable service Co-payments listed in Exhibit A to the Contract. If coverage under the Contract terminates prior to completion of implant treatment, including application of prosthetic, there may be additional charges for Implant Services rendered if treatment continues after the termination or change in the Member's dental coverage. If Implant treatment Benefits terminate before the end of the prescribed treatment period, Benefits will continue through the end of the month in which the Implant coverage was terminated.

Pre-Implant Service Co-Payment
The Member or Dependent will be responsible to pay the Co-pays listed below for Pre-Implant Services provided:

Initial Implant exam	$ 25
Diagnostic casts and X-rays	$125
Case presentation	$ 0

The Pre-Implant Co-pays will be deducted from the Implant Service Co-pay listed below.

Implant Service Co-Payment
The Member will be responsible to pay the co-payment listed below for Implant Services provided:

Single Tooth	$2,745
Two Teeth	$5,060
Three Teeth	$7,210
Full Denture (2 implants)	$4,755
Full Denture (3 implants)	$6,395
Each additional tooth	$2,315

Implant Services Provided
Surgical placement; or removal of implants; attachments to implants; or application of prosthetic.

Exclusions and Limitations
Implant Services will only be provided if the entire implant procedure (surgery and prosthetics) are performed and provided while the Member of Dependent is covered under the Contract. Only Implant services and supplies approved by the Willamette Dental Dentist will be covered under the Contract. In addition, only the Implant services and supplies listed below will be covered under the Implant Benefit. All other Implant services or supplies will either be subject to an additional co-pay as stated in this Certificate of Coverage or will not be covered:

D0160 – Implant Detailed
D0470 – Implant Records, Facebow and Study Models
D5730 – Reline Upper Implant Denture
D5731 – Reline Lower Implant Denture
D5740 – Reline Upper Implant Partial
D5741 – Reline Lower Implant Partial
D5982 – Implant Location Stent U/L
D6010 – Surgical Placement of Endosteal Implant
D6053 – Implant Removable Denture
D6054 – Implant Removable Partial
D6055 – Hader Bar Abutment Per Implant
D6056 – Prefab Abutment for Implant
D6057 – Custom Abutment for Implant
D6058 – Abutment Supported Ceramic Crn
D6059 – Abutment Supported Pfm Crn
D6062 – Abutment Supported Metal FPD
D6068 – Abutment Retainer Ceramic FPD
D6069 – Abutment Retainer PFM FPD
D6072 – Abutment Retainer Metal FPD
D6080 – Implant Maintenance Procedure
D6090 – Repair Implant Prosthesis
D6095 – Repair Implant Abutment
D6240 – Pontic-Porc/Metal Implant
D9310 – Implant Consultation