GROUP DENTAL CERTIFICATE OF COVERAGE

Policyholder Name: The Reed Institute dba Reed College

Effective Date: April 1, 2020

Group Number: OR408

This Certificate describes certain dental benefits, limitations and exclusions, offices and riders, summ

not necessarily mean the Enrollee is covered. This Certificate replaces and supersedes all prior issued certificates.

For complete details on Covered Services and other provisions of the Contract, please refer to the Contract on file with the Policyholder. If any information in this Certificate is inconsistent with the provisions of the Contract, the Certificate shall control.

Underwritten by Willamette Dental Insurance, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611

Section 1 Definitions

1.1 **"Child"** means a child of the Member (or Member's spouse or Member's domestic partner). Child includes a natural child; stepchild; adopted child; child

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

1.13 **"Member"** means an employee of the Policyholder, who is eligible and enrolled for coverage.

1.14 **"Non-Participating Provider"** means a Dentist or Denturist who is not a Participating Provider.

1.15 **"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 the Company to provide Covered Services to Enrollees. The Participating Provider agrees to charge Enrollees only the Copayments specified in the Contract for Covered Services.

1.16 **"Policyholder"** means The Reed Institute dba Reed College, the legal entity that the Contract is issued to.

1.17 **"Premium"** means the monthly payment the Policyholder must submit to the Company, including any Enrollee contributions, for coverage of each Enrollee.

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

1.19 **"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.

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

1.21 **"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.

Section 2 Eligibility and Enrollment

2.1 **Eligible Employees**. Employees must work the minimum number of hours required by the Policyholder to be eligible for coverage. Employees become eligible for coverage on the first day of the month following the date of hire for continuous employment.

2.2 **Eligible Family Members**. The Policyholder or Company may require proof of eligibility periodically.

2.2.1 The spouse of the Member or the domestic partner of the Member who has entered into

2.5.2 **Newly Acquired Family Members.** Eligible employees and their newly acquired family members may enroll following marriage or registration of a domestic partnership; court appointed legal guardianship of a Child; or issuance of a QMCSO by submitting an enrollment application and the applicable Premium to the Policyholder no later than 60 days after the event. Eligible employees or eligible family members may enroll if he/she becomes newly eligible for premium assistance under Children's Health Insurance Program (CHIP) or Medicaid by submitting an enrollment application and the applicable Premium to the Policyholder no later than 60 days after the determination for eligibility of premium assistance. Coverage will begin on the first day of the month after receipt of the enrollment application.

2.5.3 **Loss of Coverage**. Eligible employees or their eligible family members may enroll following the loss of coverage under another dental plan. Reasons for the loss of coverage may include exhaustion of COBRA continuation coverage, loss of eligibility (including as a result of legal separation, divorce, dissolution of domestic partnership, death, termination of employment, or reduction in the number of hours of employment), termination of premium assistance under CHIP or Medicaid, or reduction in employer contribution towards coverage. An enrollment application must be submitted no later than 60 days after the loss of coverage or no later than 60 days if the loss of coverage was CHIP or Medicaid. Coverage will begin on the first day of the month after receipt of the enrollment application.

Section 3 Premium

3.1 **Payment of Premium.** The payment of the Premium for each Enrollee is due on the first day of each month. The payment of the Premium must be submitted to the Company for all Enrollees in a single lump sum. A 30-day grace period is granted for payment of the Premium. If the Premium remains unpaid at the end of the grace period, the Company is released from all further obligations under the Contract. Only Enrollees for whom the Premium has been paid are entitled to Covered Services.

3.2 **Payment of Premium when Coverage is Continued.** If the Enrollee is eligible for continuation rights and elects to continue coverage, the Enrollee must submit timely payment of the Premium through the Policyholder.

3.3 **Return of Advance Payment of Premium.** The Company will refund to the Policyholder any advanced Premium payments paid for coverage after the termination of the Contract. The Policyholder must promptly notify all Enrollees of the termination of the Contract. The Participating Provider is entitled to payment of the Reasonable Cash Value of the services provided if an Enrollee receives benefits after the date of termination or for any period for which the Premium is unpaid.

Section 4 Dental Coverage

4.1 Agreement to Provide Covered Services. The Company agrees to provide benefits for prescribed Covered Services listed as covered in the appendices.

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4.5.1 Definitions

a. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
   1. Plan includes: group and individual health insurance contracts; health maintenance organization (HMO) contracts; Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
   2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each contract for coverage under subsection 4.5.1.a.1. or 4.5.1.a.2. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

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

d. Allowable Expense is a health care expense, including deductibles, coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:
   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
   2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess

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 Child is covered by more than one Plan the order of benefits is determined as follows:
   a) For a Child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls

either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph a) to the Child's parent and the Child's spouse or domestic partner.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if subsection 4.5.2.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

Section 5 Exclusions and Limitations

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

5.1.1 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.

5.1.2 The completion or delivery of treatments or services initiated prior to the effective date of coverage under the Contract, including the following:

a. Endodontic services and prosthetic services;
b. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Contract; or
c. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under the Contract.

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

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

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

5.1.5 Experimental or Investigational services and related exams or consultations.

5.1.6 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.

5.1.7 General anesthesia or moderate sedation.

5.1.8 Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees, eQq0.r Tf1 0 0 1 417.55 468.43 Tm0 g0 G[, a)-7(nd)4( )-10(prov)-6(i)5(6 Tf15MC7(P5Ba)180

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

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

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

5.1.17 Replacement of sound restorations.

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

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

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

5.1.21 Services for the diagnosis or treatment of temporomandibular joint disorders.

5.1.22 Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.

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

5.1.24 Services for the treatment of intentionally self-inflicted injuries.

5.1.25 Services for which coverage is available under any federal, state, or other governmental program, unless required by law.

5.1.26 Services that are not listed as covered in the appendices.

5.1.27 Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

5.2 Limitations.

5.2.1 **Alternate Services.** If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. If 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.

5.2.2 **Congenital Malformations.** Ser0 g0 G**[**2)]T

Section 6 Termination

6.1 Termination of Coverage. Coverage for Enrollees will terminate on the earliest of the following:

6.1.1 On the date the Contract is terminated.

6.1.2 On the last day of the month for which the Premium is paid, if the Premium is not received at the end of the grace period as specified in Section 3.

6.1.3 On the last day of the month during which eligibility ends.

6.1.4 On the last day of the month with 30 days' prior written notice to the Enrollee of good cause for termination. Good cause includes, but is not limited to, a documented inability to establish or maintain an appropriate provider-patient relationship with the Participating Provider, threats or abuse towards a Participating Provider, office staff, or other patients, or nonpayment of Copayments.

6.1.5 If coverage terminates for the Member, it will terminate for the Dependents covered under the Member.

6.2 False Statements. False statements or withholding information, with intent to affect eligibility or enrollment, affect the risks assumed by the Company, or mislead the Company into providing Covered Services it would not have otherwise provided, is a material breach of the Contract. Any ineligible person mistakenly enrolled will not be entitled to Covered Services. The Company is entitled to repayment for the Reasonable Cash Value of the Covered Services provided during the period of ineligibility from the ineligible person and any person responsible for making false statements.

6.3 Cessation of Benefits. No person is entitled to Covered Services after termination of the Contract. Termination of the Contract ends all obligations of the Company to provide Covered Services, even if the Enrollee was receiving treatment while the Contract was in force or needs treatment for any existing condition, except as specified otherwise.

6.4 Continuation Rights. The Policyholder agrees to notify all Enrollees of their rights to continuation of coverage and administer continuation of coverage in accordance with state and federal laws. For more information regarding continuation rights, Enrollees should contact the Policyholder.

6.4.1 Leave of Absence. Coverage may be continued during a temporary, employer approved leave of absence for up to 3 months. For more information regarding coverage during a leave of absence, please contact the Policyholder.

6.4.2 Federal or State-Mandated Continuation Coverage. Coverage for Enrollees may continue during a leave of absence taken in accordance with applicable federal or state-mandated leave or continuation of coverage laws. This includes, but is not limited to continuation of coverage for a legally separated, divorced, or surviving spouse age 55 or over and any eligible Children whose coverage under the Contract otherwise would terminate due to the legal separation, divorce, or death, as required under Oregon state

law. For more information regarding state-

6.6.3 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.

6.6.4 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.

6.6.5 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 7 General Provisions

7.1 **Subrogation.** 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 Company and the Participating Provider are not acting as volunteers and are not

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

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

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

7.2.2 Grievances.

a. A grievance is a written complaint expressing dissatisfaction with a service provided by the Company or other matters related to the Contract. 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 Company will review the grievance and all information submitted. The Company will provide a written reply no later than 30 days after receipt. If additional time is needed, the Company will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws. If the grievance involves:

1. A preauthorization, the Company will provide a written reply no later than 15 days after the receipt of a written grievance.
2. Services deemed Experimental or Investigational, the Company 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 Company 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.

7.2.3 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. Appeal request 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 info by the Company or o 792 re200 1 [r)-3(el)7(e)-9(v)6r(c)-5(a7208.0

3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours after 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.

7.2.4 Authorized Representative. Enrollees may authorize another person to represent the Enrollee and to whom the Company can communicate regarding a specific grievance or appeal. The authorization must be in writing and signed by the Enrollee. The appeal

Appendix A - Schedule of Covered Services and Copayments

Office Visit Copayments

General Office Visit Copayment $10
Specialist Office Visit Copayment $30

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	$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	Cephalometric radiographic image	$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
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cement or re-bond of space maintainer	$0
D1555	Removal of fixed space maintainer	$0

2. Restorative Services

4. 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)	$30
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$60
D3330	Endodontic therapy, molar (excluding final restoration)	$90
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	

D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$50
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$50
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$50
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in the same graft site	$50
D4341	Periodontic scaling and root planing - 4 or more teeth per quadrant	$30
D4342	Periodontic scaling and root planing - 1 to 3 teeth per quadrant	$30
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0
D4910	Periodontic maintenance	$0

6. Prosthodontics - Removable

D5110	Complete denture - maxillary	$100
D5120	Complete denture - mandibular	$100
D5130	Immediate denture - maxillary	$100
D5140	Immediate denture - mandibular	$100
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$100
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	

D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline c 0 0 20.85 697.42 Tm0 G[ )]TJETQq103.58 693.58 405.07 13.2 reW*nBT/F1 9.96 Tf3	

D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$50
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)	$50
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$50
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

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 the Contract. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

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

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 are based on the Reasonable Cash Value after coverage terminates.

e. The Enrollee is responsible for payment of the Copayments listed below for pre-ETQ 0 003 Tm0 G[-)]TJETQ

Appendix C - Dental Implants

1. Benefits.

a. The dental implant services described in this Appendix C 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 C 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**. The annual dental implant benefit maximum is the maximum dollar amount the Contract 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 are limited to 1 implant per calendar year.
b. Dental implants to replace an existing bridge or existing denture are not covered, unless **5** years have elapsed since the placement of the bridge or delivery of the denture.

3. Exclusions. epl ret 1 144.022261 an44.262f6 Tf1 0 0 1 15d s dent262foBT/270 Gi