LifeMap Assurance Company®
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GROUP MANAGED CARE DENTAL INSURANCE
PLAN 1 CERTIFICATE OF COVERAGE

POLICYHOLDER: NORTHWEST AUTO TRADES ASSOCIATION (NATA/OATO)

POLICY NUMBER: OR 013928

REVISED EFFECTIVE DATE: OCTOBER 1, 2020

This is to certify that LifeMap Assurance Company has issued and delivered the Group Dental Insurance Policy to the Policyholder. The Policy insures the Employees of the Policyholder who are eligible for the insurance, become insured, and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Certificate of Coverage describes the benefits that an Enrolled Employee is entitled to receive and becomes a part of the Policy. **PLEASE READ THIS CERTIFICATE CAREFULLY**.

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Assistant Secretary

President

NON-PARTICIPATING

CERTIFICATE OF COVERAGE
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DENTAL COVERAGE OUTLINE

Eligible Classes: Class 01 - All eligible Members of Participating Employers of the Policyholder who are enrolled in Group Managed Care Dental Plan 1.

Eligibility Waiting Period: Determined by each Participating Employer.

Employee Contribution:

Employee:	Contributory
Dependents:	Contributory

BENEFITS SCHEDULE

Calendar Year Deductible	None
Benefit Waiting Period	
Orthodontic Services	6 Months
Calendar Year Maximum	None
Visit Charge	$6.00
Service Copay	See the Schedule of Covered Services and Copays

The Member must receive services from a Participating Provider for services to be covered under this Policy, except as otherwise specified in this Policy for emergency care and referrals.

The Participating Providers agree that they will accept fees in the amount established by us as full payment for Covered Services except for the Visit Charge and Service Copay, which are the Member's responsibility. The Participating Providers agree that their charges to the Member for Covered Services provided will not exceed the Service Copay amounts specified in the Schedule of Covered Services and Copays of this Policy.

A list of the Willamette Dental Group, P.C. offices at which the Participating Providers offer services and contact information can be found online at www.willamettedental.com.

DEFINITIONS

Wherever used in this Policy, the following definitions will apply to the terms listed below. The masculine will include the feminine and the singular will include the plural.

"You" and **"your"** mean the Enrolled Employee. **"We," "us"** and **"our"** mean LifeMap Assurance Company.

Active Employment means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Dental Coverage Outline;
2. receiving regular Earnings from the Employer; and
3. employed:
   a) at the Employer's usual place of business; or
   b) at a location to which the Employer's business requires the Employee to travel.

Application means the document showing the eligible classes, amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the Policyholder. This document is attached to and forms a part of the Policy.

Benefit means services and supplies covered under this Policy.

Benefit Waiting Period means the continuous length of time the Member must be covered under the Policy before becoming eligible for Benefits.

Calendar Year means the period from January 1 through December 31 each year.

Certificate is the description of the benefits for this coverage. The Certificate is part of the Policy between the Employer Group and us.

Covered Service means a:

1. service;
2. supply; or
3. treatment

listed in the Schedule of Covered Services and Copays of the Policy.

Dental Emergency means the emergent and acute onset of a symptom or symptoms that would lead a prudent person acting reasonably to believe that a condition exists that requires immediate attention, if failure to provide immediate attention would result in serious impairment to bodily functions or serious dysfunction of a bodily part, or would place the person's health in serious jeopardy. (A prudent person is someone who has an average knowledge of health and medicine.) The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or Prosthetic Services.

***Domestic Partner (Non State-Certified)** means an adult of the same or opposite sex who has an emotional, physical and financial relationship with you, similar to that of a spouse, as evidenced by the following facts:

1. you and your domestic partner share a residence and the financial responsibility for the joint household and intend to continue an exclusive relationship indefinitely;
2. you and your domestic partner each are at least eighteen (18) years of age;
3. you and your domestic partner are both mentally competent to enter into a binding contract;
4. neither you nor your domestic partner are married to or legally separated from anyone else;
5. you and your domestic partner are not related to one another by blood closer than would bar marriage; and
6. neither you nor your domestic partner is a domestic partner of anyone else.

*Coverage provided only if elected by your Participating Employer. See your Benefits Administrator for more information.

Effective Date means the date specified by us, following our acceptance of the application for coverage, as the date coverage begins for you and/or your Enrolled Dependents.

Eligibility Waiting Period means the continuous length of time you must be in Active Employment before becoming eligible for coverage under the Policy.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Application or any Policy amendments.

Enrolled Dependent means:

1. an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's application for coverage;
2. whose application is accepted by us; and
3. who is enrolled under this Policy.

Enrolled Employee means an employee of the Policyholder who is eligible under the terms of the Policy, whose application we have accepted, and who is enrolled under this coverage.

Experimental/Investigational for the purposes of this Policy means a service or supply which does not meet all of the following criteria:

1. the services or supplies are in general use in the dental community in the State of Oregon;
2. the services or supplies are under continued scientific testing and research;
3. the services or supplies show a demonstrable benefit for a particular illness, disease, or condition; and
4. the services or supplies are proven safe and effective.

Family means an Enrolled Employee and his or her Enrolled Dependents.

Immediate Family means parents, Spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage who shares a residence with you.

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

Licensed Denturist means a denturist licensed in the state where treatment is rendered, who is acting within the scope of his or her license.

Member means the Enrolled Employee or an Enrolled Dependent.

Necessary Dental Service means a dental service recommended by the treating Participating Provider, who has personally evaluated the Member, and determined by the Participating Provider to be all of the following:

1. appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
2. appropriate for the diagnosed condition, disease, or injury;
3. in accordance with recognized national standards of care;
4. could not have been omitted without adversely affecting the Member's condition; and
5. not primarily for the convenience of the Member, Member's family, or provider.

A dental service may be a "Necessary Dental Service" yet not be a Covered Service under this Policy.

Participating Provider means Willamette Dental Group, P.C., and the providers who are employed by or are under contract with Willamette Dental Group, P.C., or any of its affiliates, to provide dental services to the Member.

Participating Providers include the following:

1. **Participating Dentist**: A Licensed Dentist who is employed by or is under contract with Willamette Dental Group, P.C., as specified above.
2. **Participating Denturist***:* A Licensed Denturist who is employed by or is under contract with Willamette Dental Group, P.C., as specified above.

Policy, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

Policy Year means the 12-month period following either the Policy's original Effective Date or subsequent renewal date. A Policy Year may or may not be the same as a Calendar Year. This Policy is renewed, with or without changes, each Policy Year.

Policyholder means the person, individual firm, trust or other organization named in the Application for the Policy and shown on the face page of this Policy.

Reasonable Cash Value means the Participating Provider's usual, customary, and reasonable fee for services and supplies.

Service Copay means the amount that will be the Member's responsibility to pay for each Covered Service received under this Policy as specified in the Schedule of Covered Services and Copays. All Service Copay amounts are paid directly to the Participating Provider at the time of the visit. The Service Copay is in addition to the Visit Charge.

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 Provider.

Spouse means the Employee's legal wife, husband, or state certified domestic partner. Each Participating Employer determines if coverage for non-state certified domestic partners and children of non-state certified domestic partners is provided. See your Benefits Administator for more information.

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

Visit Charge means the dollar amount that will be the Member's responsibility to pay for each visit to a Participating Provider. All Visit Charges are paid directly to the Participating Provider at the time of the visit. In addition to the Visit Charge, the Member may be responsible to pay a Service Copay for procedures as specified in the Schedule of Covered Services and Copays.

Willamette Dental Group, P.C. means the Oregon corporation which has signed a participating agreement with us, on behalf of itself and its affiliates, to provide dental services to the Member.

ELIGIBILITY AND ENROLLMENT

Initially Eligible
You will be entitled to apply for coverage for yourself and your eligible dependents within 31 days of your first becoming eligible for coverage according to the eligibility requirements in effect with the Policyholder and as stated below. Coverage for you and your enrolling eligible dependents will commence on the Effective Date.

Employees
You become eligible to apply for coverage on the date you have worked for the Policyholder long enough to satisfy any required Eligibility Waiting Period.

Dependents
Your Enrolled Dependents are eligible for coverage when you have listed them on your application or on subsequent change forms and when we have accepted them for coverage under the Policy. Dependents are limited to the following:

1. Your Spouse; or
2. Your or your Spouse's "dependent" child who is under age 26, unmarried, not in a domestic partnership, and who meets any of the following criteria:
    1. your or your Spouse's natural child, stepchild, adopted child, or child legally placed with you or your Spouse for adoption;
    2. a child for whom you or your Spouse have court-appointed legal guardianship;
    3. a child for whom you or your Spouse or are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your or your Spouse's child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday will continue to be covered if you submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your or your Spouse's Effective Date.

Newly Eligible Dependents
You may enroll a dependent who becomes eligible for coverage after your Effective Date by completing and submitting an enrollment request to us. Request for enrollment of a new dependent child by birth, adoption, or placement for adoption must be made within 60 days of the date of birth, adoption, or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 31 days of the dependent's attaining eligibility. Coverage for such dependents will commence on their Effective Dates (which, for a new dependent child by birth, adoption, or placement for adoption, is the date of birth, adoption, or placement for adoption, if enrolled within the specified 60 days).

You must promptly furnish any information necessary and appropriate to determining the eligibility of a dependent. Receipt of such information by us will be a condition precedent to enrolling a person as a dependent under the Policy.

Annual Enrollment Period
The Annual Enrollment Period is the period of time to be determined by the Policyholder and us during which you and/or your eligible dependents may enroll for coverage if you and and/or your eligible dependents did not enroll when initially eligible. You must submit an application on behalf of all dependents you wish to enroll. Coverage for you and your enrolling eligible dependents will commence on the Effective Date.

Note: If you voluntarily terminate your coverage, you will not have the opportunity to re-enroll during the next Annual Enrollment Period following your termination date.

DENTAL BENEFITS

EMERGENCY CARE - Members should first seek treatment from a Participating Provider for a Dental Emergency. If Participating Provider offices are closed, the Member may access afterhours clinical assistance by calling the Appointment Center at (800) 461-8994. When emergency services are provided after normal business hours at a Participating Provider office, the Member will be responsible for both the Visit Charge and an additional Service Copay as specified Schedule of Covered Services and Copays.

In the event of a Dental Emergency when the Member is more than 50 miles from a Participating Provider office:

The Member may seek treatment from any dentist for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Willamette Dental Group, P.C. office.

The Member may seek reimbursement for the cost of the Covered Services rendered up to the Out of Area Emergency Reimbursement amount, per occurrence, as specified in the Schedule of Covered Services and Copays. Based on the services received the Member will remain responsible for any Service Copay amounts as if the Member had been seen by a Participating Provider.

A written request for reimbursement must be submitted per the instructions in the Claims for Reimbursement of Emergency Treatment provision of this Policy.

ORTHODONTIA SERVICES – The Member must be covered under this Policy for a period of 6 months to be eligible for Benefits for orthodontic treatment. Orthodontic services will be provided by a Participating Provider when a treatment plan is prepared by a Participating Provider prior to rendering orthodontic services. No Benefits will be provided for any appliances provided prior to rendering treatment.

The treatment plan is based on an examination that must take place while the Member is covered under this Policy, and the examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care. Additional services connected with orthodontic treatment will be provided subject to the Service Copay amounts found in the Schedule of Covered Services and Copays.

Once active orthodontic treatment ends, the Member must follow the post-treatment plan and keep all follow-up appointments after the Member is de-banded to avoid additional orthodontic Service Copays. Such additional orthodontic treatment would be considered to be a new case.

To receive the full Benefits of this Policy the Member must remain covered under this Policy for the entire length of treatment. If coverage terminates prior to completion of treatment, the Service Copay will be prorated according to the extent of services received prior to termination and the charges for any remaining services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

REFERRALS - The services of a Specialist will only be covered upon referral by a Participating Provider. The Member will be responsible for charges by the Specialist for procedures other than those specifically authorized by the Participating Provider and for any services not covered under this Policy.

BENEFITS – The Member is responsible for payment of the Visit Charge and any applicable Service Copays at the time of service. Please see the following Schedule of Covered Services and Copays for a complete description of the Benefits provided by this Policy with the applicable Service Copays listed. If alternative Covered Services can be used to treat a Member's dental condition, the Covered Service which is recommended by the treating Participating Provider will be covered.

Schedule of Covered Services and Copays

	Service Copay (You pay the amount noted)
Diagnostic and Preventive Services	
Oral evaluation or examination	$0
Complete series of x-rays	$0
Periapical x-ray - first film	$0
Intraoral or Extraoral x-rays	$0
Bitewing x-rays	$0
Panoramic x-rays	$0
Oral / facial images	$0
Caries Susceptibility Tests	$0
Pulp vitality test	$0
Diagnostic casts	$0
Teeth cleaning (prophylaxis)	$0
Topical fluoride treatment	$0
Nutritional Counseling	$0
Tobacco counseling	$0
Oral Hygiene Instruction	$0
Sealant (per tooth)	$0
Space Maintainers	
Space Maintainers	$0
Space Maintainer - recement	$0
Removal of fixed space maintainer	$0
Restorative Services	
a) Amalgam Restorations	
Fillings	$0
Sedative filling - temporary	$0
Pin retention, in addition to restoration (per tooth)	$0
b) Resin Restorations	
Resin, anterior only	$0
Resin based composite crown	$0
Resin, posterior primary	$0
Resin - 1 surface, posterior permanent	$0
Resin - 2 to 4 surfaces, posterior permanent	$0
c) Inlay/Onlay (cast restorations)	
Inlay/Onlay - gold or porcelain/ceramic	$25
Recement inlay/onlay	$0
Crowns	
Crown (resin based composite, porcelain-noble, or 3/4 noble metal)	$25
Crown (stainless steel)	$0
Crown (prefabricated resin or prefabricated stainless steel with resin window)	$25
Recement crown	$0
Core buildup, including any pins	$0
Prefabricated dowel post & core	$0
Post removal (no endodontic therapy)	$0
Crown repair	$0

Schedule of Covered Services and Copays

	Service Copay (You pay the amount noted)
Endodontic Services	
Pulp cap	$0
Pulpotomy - A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	$0
Gross pulpal debridement - primary & permanent teeth	$0
Pulpal therapy	$0
Root canal therapy - anterior	$20
Root canal therapy - bicuspid	$40
Root canal therapy - molar	$60
Treatment of root canal obstruction - non-surgical access	$0
Incomplete endodontic therapy - inoperable or fractured tooth	$0
Internal repair of perforation defects	$0
Retreatment - anterior	$20
Retreatment - bicuspid	$40
Retreatment - molar	$60
Apexification - initial visit	$60
Apexification - interim or final visit	$0
Apicoectomy - anterior	$20
Apicoectomy - bicuspid 1st root	$40
Apicoectomy - molar 1st root	$60
Apicoectomy - each additional root	$0
Retrograde filling (per root)	$0
Root amputation (per tooth)	$60
Hemisection	$60
Canal preparation-preform dowel/post	$0
Periodontic Services	
Gingivectomy or gingivoplasty	$25
Gingival flap	$20
Crown lengthening - hard tissue	$25
Osseous surgery	$25
Bone replacement graft	$0
Pedicle or free soft tissue graft procedure	$25
Subepithelial connective graft	$25
Distal wedge procedure	$25
Periodontal scaling and root planing	$20
Preliminary full-mouth debridement	$0
Antimicrobial irrigation	$0
Periodontal maintenance	$0
Prosthetic Services - Removable	
Complete denture - upper or lower	$25
Immediate denture - upper or lower	$25
Partial base, resin - upper or lower	$25
Partial cast, metal frame - upper or lower	$25
Removable unilateral partial denture	$25
Adjust complete or partial denture - upper or lower	$0
Repair broken denture - no teeth damaged	$0
Repair broken denture - replace missing or broken teeth (per tooth)	$0
Repair resin base	$0

Schedule of Covered Services and Copays

	Service Copay (You pay the amount noted)
Prosthetic Services - Removable (cont'd)	
Repair partial cast framework	$0
Repair or replace partial clasp	$0
Replace teeth - partial (per tooth)	$0
Add tooth or clasp to existing partial denture	$0
Replace all teeth and acrylic on cast mental framework - upper or lower	$0
Rebase complete or partial denture - upper or lower	$0
Reline complete or partial denture - upper or lower - chairside	$0
Reline complete or partial denture - upper or lower - lab	$0
Interim complete or partial denture - upper or lower	$12
Tissue conditioning - upper or lower	$0
Overdenture - complete or partial	$25
Fluoride gel custom trays	$0
Prosthetic Services - Fixed	
Pontic - cast or porcelain/metal traditional fixed partial dentures only bridges (per tooth)	$25
Pontic - maryland bridge (per tooth)	$25
Cast metal retainer	$25
Crown - resin/metal or porcelain metal abutment	$25
Crown ¾ cast metal abutment	$25
Crown - full gold abutment	$25
Recement bridge	$0
Prefabricated post/core in addition to bridge	$0
Core build-up, with or without pins	$0
Coping - metal	$0
Bridge repair	$0
Oral Surgery	
Extraction - coronal remnants primary tooth	$0
Extraction - erupted tooth	$0
Surgical extraction - erupted tooth	$20
Removal of impacted tooth	$20
Surgical removal of residual root	$20
Oroantral fistula closure	$20
Tooth re-implantation	$20
Surgical access of an unerupted tooth	$20
Orthodontia bracket to aid eruption of impacted tooth`	$20
Alveoloplasty with or without extractions, per quadrant	$0
Removal of lateral exostosis - maxilla or mandible	$20
Remove non-vital bone segment	$0
Incision and drainage of an abscess – intraoral or extraoral soft tissue	$0
Removal of foreign body - soft or hard tissue	$0
Partial ostectomy/sequestrectomy for removal of non vital bone	$0
Stabilization - splint alveolus	$0
Suture of a small wound - up to 5 cm	$0
Complicated suture - up to 5 cm	$0
Bone replacement graft for ridge preservation - per site	$20
Frenectomy	$20
Excision hyperplastic tissue	$20
Excision of pericoronal flap	$20

Schedule of Covered Services and Copays

	Service Copay (You pay the amount noted)
Anesthesia	
Nitrous Oxide (per visit)	$20
Orthodontic Services (After the 6 month Benefit Waiting Period)	
a) Pre-orthodontic Service Copays (not to exceed $150 per case)	
Initial orthodontic exam	$25
Study models and x-rays	$50
These Pre-orthodontic Service Copays will be deducted from the Orthodontic Service Copay specified below if the Member elects to receive orthodontic treatment.	
b) Comprehensive Orthodontic Service Copay	$2,800
Includes the following treatments:	
Limited and comprehensive orthodontic treatment of the transitional, adolescent, and adult detention.	
Interceptive orthodontic treatment of the transitional detention.	
Miscellaneous	
Palliative (emergency) treatment of dental pain-minor procedure	$0
Fixed Partial Bridge Sectioning	$0
Consultation - per session	$0
Observation visit	$0
Treatment after office hours	$10
Application of desensitizing medicament	$0
Application of desensitizing resin for cervical and/or root surface (per tooth)	$0
Occlusal adjustment - simple	$0
Enamel microabrasion	$0
Out of Area Emergency Reimbursement	Charges in excess of $100
(We will reimburse up to $100 of Covered Services. Service Copays will still apply.)	

EXCLUSIONS

The following are the general exclusions from coverage under the Policy. Other exclusions may apply and, if so, will be described elsewhere in the Policy. No Benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, **including any direct complications or consequences that arise from them**, unless otherwise specified.

Aesthetic Dental Procedures and complications arising out of such services**.** Including services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Benefits not stated meaning services and supplies that are not identified as Benefits under the Policy.

Charges by any person other than a Participating Provider except for those instances indicated in the Benefits section of this Policy.

Cosmetic/Reconstructive Services and Supplies, except in the treatment of the following:

1. to treat a congenital anomaly for Members up to age 18; or
2. to restore a physical bodily function lost as result of injury or illness.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance and that do not primarily restore an impaired function of the body.

Reconstructive means:

1. services, procedures, and surgery performed on abnormal structures of the body that were caused by congenital defects; or
2. developmental abnormalities, trauma, infection, tumors, or disease.

Reconstructive services are generally performed to restore function, but also may be done to approximate a normal appearance.

For the purposes of this exclusion, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

Coverage that is available under any federal, state, or other governmental program if application is duly made therefore, except where required by law, such as for cases of emergency or for coverage provided by Medicaid.

Dental implants, including attachment devices and their maintenance; crowns over implants.

Dental services which are not Necessary Dental Services as defined by this Policy.

Diagnostic Casts or Study Models

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 Effective Date under this Policy or if the item was installed or delivered more than 60 days after the Member's coverage under this Policy has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within 60 days after termination.

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

Experimental/Investigational treatments, procedures and services, supplies, and accommodations provided in connection with Experimental/Investigational treatments or procedures.

Extraction of permanent teeth for tooth guidance procedures; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; craniomandibular orthopedic treatment; and other orthodontic treatment, unless specified in the Schedule of Covered Services and Copays.

Full-mouth reconstruction.

General Anesthesia, including conscious sedation and intravenous sedation, unless specified in the Schedule of Covered Services and Copays.

Habit-breaking or stress-breaking appliances

Hospitalization for dentistry.

Maxillofacial prosthetic services.

Medication and Supply Charges including take home drugs, pre-medications, therapeutic drug injections, and supplies.

Military Service-Related Conditions which includes services and supplies for treatment of an illness or injury caused by or incurred during service in the armed forces of any state or country.

Motor Vehicle Coverage and Other Insurance Liability means any expenses for services and supplies that are payable under any:

1. automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage;
2. homeowner's coverage;
3. commercial premises coverage; or
4. similar policy or insurance.

This applies when the policy or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such policy or insurance are exhausted or deemed to no longer be injury-related under the no-fault provisions of the Policy, we will provide Benefits according to the Policy.

Non-Direct Patient Care and services that are not direct patient care, including:

1. charges for appointments scheduled and not kept ("missed appointments");
2. charges for preparing medical reports, itemized bills or claim forms (even at our request); or
3. visits or consultations that are not in person (including telephone consultations and e-mail exchanges)

whether initiated by the Member or the Member's provider.

Occlusal Treatment and supplies provided in connection with dental occlusion, including the following:

1. complete occlusal adjustments; and
2. occlusal guards.

Personalized restorations, precision attachments, and special techniques.

Repair or Replacement Services and supplies provided in connection with the repair or replacement of any dental appliance (including but not limited to dentures and retainers), whether lost, stolen, or broken.

Replacement of sound restorations.

Riot, Rebellion, War and Illegal Acts including services and supplies for treatment of:

1. an illness or injury caused by a Member's unlawful instigation and/or active participation in a riot or war, whether declared or undeclared; armed invasion or aggression, insurrection, or rebellion; or
2. services and supplies for treatment of an illness or injury sustained by a Member while in the act of committing an illegal act.

Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.

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

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

Temporomandibular Joint (TMJ) Dysfunction Treatment. Services and supplies provided in connection with Temporomandibular Joint (TMJ) dysfunction.

Transseptal fiberotomy.

Treatment started prior to the Member's Effective Date under this Policy or completed after this Policy terminates, unless otherwise stated.

Work-Related Injuries and expenses for services and supplies incurred as a result of any work-related injury, including any claims that are resolved pursuant to a disputed claim settlement for which a Member has or had a right to compensation.

We may require the Member to file a claim for workers' compensation benefits prior to providing any Benefits under the Policy. Services and supplies received for work-related injuries are not covered even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Member is exempt from state or federal workers' compensation law.

WHEN COVERAGE ENDS

This section describes the situations when coverage will end for you and/or your Enrolled Dependents. If one of your Enrolled Dependents is no longer eligible for this coverage, you must notify us within 30 days.

No person will have a right to Benefits under this Policy after the date it is terminated. Termination of your or your Enrolled Dependent's coverage under this Policy for any reason will completely end all our obligations to provide you or your Enrolled Dependent Benefits for Covered Services received after the date of termination. This applies whether or not you or your Enrolled Dependent is then receiving treatment or is in need of treatment for any illness or injury incurred or treated before or while this Policy was in effect.

Policy Termination or Non Renewal by the Policyholder or by us means coverage ends for you and your Enrolled Dependents on the date the Policy is terminated or not renewed

In the event this Policy is terminated and coverage is not replaced by the Policyholder, we will mail to the Policyholder a notice of termination. It is then the duty of the Policyholder to send each Enrolled Employee a notice of the termination, explaining rights to continuation or portability of coverage under federal and/or state law.

If You Are No Longer Eligible as explained in the following paragraphs, you and your Enrolled Dependents' coverage ends on the last day of the monthly period in which your eligibility ends. However, it may be possible for you and/or your Enrolled Dependents to continue coverage under the Policy according to the continuation of coverage provisions of this Certificate.

Termination of Your Employment or You Are Otherwise No Longer Eligible
If you are no longer eligible due to termination of employment or you are otherwise no longer eligible according to the terms of the Policy, your coverage will end for you and all Enrolled Dependents on the last day of the monthly period following the date on which eligibility ends.

Nonpayment of Premium
If you fail to make required timely contributions to premium, your coverage will end for you and all Enrolled Dependents on the last day of the period for which you have made any required contribution.

Termination by You
You have the right to terminate this coverage with respect to yourself and your Enrolled Dependents by giving notice to us. Coverage will end on the last day of the monthly period following the date we receive such notice.

NOTE: If you voluntarily terminate coverage for yourself or an Enrolled Dependent, you will not have the opportunity to re-enroll during the next Annual Enrollment Period following your termination date.

Fraudulent Use of Benefits
If you or your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of fact in connection with coverage, coverage under this Policy will terminate for that Member. If this coverage terminates for an Enrolled Employee, it will also terminate for the Employee's Enrolled Dependents.

Fraud or Misrepresentation in Application
We have issued this coverage in reliance upon all information furnished to us by you or on behalf of you and your Enrolled Dependents. In the event of any intentional material misrepresentation of fact or fraud regarding a Member (including, but not limited to a person who is listed as a dependent, but does not meet the eligibility requirements listed in this Certificate), coverage under this Policy will terminate for such Member.

Family and Medical Leave is applicable if Your Employer grants you a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA").

The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent you are eligible for leave under the terms of the FMLA. The following rules apply:

1. You and your Enrolled Dependents will remain eligible to be enrolled under the Policy during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
   a) in order to care for your newly born child;
   b) in order to care for your Spouse, child, or parent, if such spouse, child, or parent has a serious health condition;
   c) the placement of a child with you for adoption or foster care; or
   d) you suffer a serious physical or mental health condition.

During the FMLA leave, timely payment of the monthly premium must continue to be made through the Employer. The provisions described here will not be available if this Policy terminates.

If you and/or your Enrolled Dependents elect not to remain enrolled during the FMLA leave, you (and/or your Enrolled Dependents) will be eligible to be reenrolled under the Policy on the date you return from the FMLA leave. In order to reenroll after you return from a FMLA leave, you must complete and sign a new application just as if you were a newly eligible employee. In this situation, if you reenroll within the required time, all of the terms and conditions of the Policy will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or your Enrolled Dependents) will receive credit for any waiting period served prior to the FMLA leave and you will not have to re-serve any probationary period under this Policy, although you and/or your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to employers that are required by law to comply. The Employer must keep us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

Leave of Absence

If you are granted a non-FMLA temporary leave of absence by your Employer, you can continue coverage for up to three months. Premiums must be paid through the Employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by your Employer at your request during which you are still considered to be employed and are carried on the employment records of the Employer. A leave can be granted for any reason acceptable to the Employer. If you are on leave for an FMLA-qualifying reason, you remain eligible under the Policy only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

When Your Enrolled Dependents Are No Longer Eligible
If your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Policy according to the continuation of coverage provisions of this Certificate.

Divorce, Annulment or Termination of State Certified Domestic Partnership
Eligibility ends for your enrolled Spouse and the Spouse's children (unless such children remain eligible by virtue of their continuing relationship to you) on the last day of the monthly period following the date a divorce, annulment or termination of state certified domestic partnership is final.

If You Die
If you die, coverage for your Enrolled Dependents ends on the last day of the monthly period in which your death occurs.

Loss of Dependent Status

1. for an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit; or
2. for an enrolled child who marries, eligibility ends on the last day of the monthly period in which the marriage occurs; or
3. for an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement; or
4. for an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

Certificates of Creditable Coverage
Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Policy should be directed to the Policyholder or to us at PO Box 1271, M/S E8L, Portland, OR 97207-1271.

COBRA CONTINUATION OF COVERAGE

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups. Complete details are available from your Employer.

If your Employer is subject to COBRA, COBRA continuation is available to your Enrolled Dependents if they lose eligibility because:

1. your employment is terminated (unless the termination is for gross misconduct); or
2. your hours of work are reduced; or
3. you die; or
4. you and your Spouse divorce, the marriage is annulled or your domestic partnership is terminated; or
5. you become entitled to Medicare benefits; or
6. your Enrolled Dependent loses eligibility as a dependent child under this coverage.

COBRA also is available to you if you lose eligibility because your employment terminates (other than for gross misconduct) or your hours of work are reduced. (A special COBRA continuation also applies to you and your Enrolled Dependents under certain conditions if you are retired and your Employer files for bankruptcy. Complete details are available from your Employer.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods. See your Employer for details.

General Rules

Generally, you or your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Employer contributes toward the premiums of those not on COBRA continuation. The administration fee is 2% or, during any period of extension for disability, 50%.

In order to preserve your and your Enrolled Dependent's rights under COBRA, you or your Enrolled Dependents must inform the Employer in writing within 60 days:

1. of your divorce, annulment, termination of domestic partnership, or loss of dependent child status; or
2. if your initial loss of eligibility was due to your termination of employment or reduction in working hours and you experience another one of the events listed above; or
3. a Social Security disability determination that you or your Enrolled Dependent was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that you or your Enrolled Dependent is no longer disabled for Social Security purposes, you or your Enrolled Dependent must provide the Employer notice of that determination within 30 days of the date it is made.)

The Employer also must meet certain notification, election and payment deadline requirements. It is therefore very important that you keep the Employer informed of the current address of all Members who are or may become qualified beneficiaries.

If you or your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Policy will end according to the terms of the Policy and we will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize your or your Enrolled Dependents' future eligibility for an individual plan.

OTHER CONTINUAITION OPTIONS

This section describes situations when coverage may also be extended for you and/or your Enrolled Dependents beyond the date of termination.

Reenrolling After Layoff

This provision applies only when the health plan of the Employer is not subject to the continuation of coverage provisions of COBRA. If you are rehired and return to active work within 6 months of being laid off, you and any previously Enrolled Dependents may reenroll under this Policy on the date you are rehired, regardless of any lapse in coverage. Your Employer must notify us that you are being rehired following a layoff and the necessary premiums for your coverage must be paid. All Policy provisions will resume at the time you reenroll whether or not there was a lapse in your coverage. Any Benefit Waiting Period not completed at the time the employee was laid off must be satisfied. However, the period of your layoff will be counted toward the Benefit Waiting Period. At the time you are rehired, you do not have to re-satisfy any Eligibility Waiting Period required by this Policy.

THIRD PARTY LIABILITY

This provision will apply in the event any person covered by this Policy receives treatment in connection with an illness or injury for which one or more third parties may be responsible. In that situation, Benefits are excluded under this Policy to the extent you or your Eligible Dependent receive a recovery from or on behalf of the responsible third party.

The following rules will apply to third party liability situations:

1. If a Participating Provider provides services for treatment of an illness or injury which is allegedly the liability of a third party, you or your Eligible Dependent must agree in writing to hold any recovery in trust for the Participating Provider up to the Reasonable Cash Value of the Benefits. The Participating Provider may require that you or your Eligible Dependent sign an agreement guaranteeing the provider's right to reimbursement before providing services.

2. The Participating Provider is entitled to full reimbursement for the Reasonable Cash Value of the Benefits provided from the proceeds of any recovery you or your Eligible Dependent receive from or on behalf of the third party. This is so regardless of whether:

    a) the recovery is the result of a court judgment, arbitration award, compromise settlement or any other arrangement;
    b) the third party or the third party's insurer admits liability; or
    c) the dental care services are itemized or expressly excluded in the third party recovery.

3. A proportionate share of the reasonable expenses of obtaining a recovery, such as attorney fees and court costs, may be deducted from the amount to be reimbursed to the Participating Provider.

MOTOR VEHICLE COVERAGE

In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage. Benefits for dental care are excluded under this Policy to the extent that you or your Eligible Dependent are able to or are entitled to recover from motor vehicle insurance, but we will provide Benefits for Covered Services over the amount covered by motor vehicle insurance.

The following rules will apply to motor vehicle insurance coverage:

1. If a Participating Provider provides services for treatment of an injury arising out of a motor vehicle accident and motor vehicle insurance has not yet paid, you or your Eligible Dependent must agree in writing:

    a) to give the Participating Provider information about any motor vehicle insurance coverage which may be available to you or your Eligible Dependent; and
    b) to hold the proceeds of any recovery from motor vehicle insurance in trust for the Participating Provider and reimburse the Participating Provider as provided below.

2. The Participating Provider is entitled to reimbursement in the amount of the Reasonable Cash Value of the Benefits provided out of any subsequent motor vehicle insurance recovery or payment made to or on behalf of you or your Eligible Dependent, whether such recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage.

4 You or your Eligible Dependent who was involved in a motor vehicle accident may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the "Third Party Liability" section will apply.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES -- This Certificate is furnished in accordance with and subject to the terms of the Policy. The entire contract consists of the Policy, which includes the Application, and any attached papers; this Certificate; and any riders or endorsements. No change in the Policy will be effective until approved by one of our officers. This approval can only be made in writing and must be noted on or attached to the Policy. No agent has authority to change the Policy or Certificate or to waive any of their provisions.

CERTIFICATES -- The Employer is responsible for giving to the Enrolled Employee a complete copy of the Certificate for the Enrolled Employee's applicable class within 31 days after receipt of the Certificates from us.

AGENCY -- For all purposes under this Policy the Policyholder acts on its own behalf or as agent of the Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

INCONTESTABILITY -- In the absence of fraud, all statements you make in an application will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by you, a copy of which is furnished to you.

NO WAIVER -- The failure or refusal of either party to demand strict performance of this Policy or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Policy will be deemed waived by us unless such waiver is reduced to writing and signed by one of our authorized officers.

LEGAL ACTIONS -- No legal action may be brought to recover on this Policy until 60 days after proof of loss has been furnished. No action may be brought after 3 years from the time written proof of loss is required to be furnished.

LIMITATIONS ON LIABILITY -- Participating Provider facilities and professionals are neither employees nor agents of LifeMap Assurance Company. Providers are responsible for the quality of care they render Since we do not provide any dental care services, we cannot be held liable for any claim or damages connected with injuries you suffer while receiving dental services or supplies provided by professionals who are neither our employees nor agents.

DELAYED SERVICES DUE TO CIRCUMSTANCES BEYOND CONTROL -- When circumstances caused by an act of God or other causes beyond the control of a Participating Provider delay or prevent dental services under this Policy, neither we nor the Participating Provider will be liable for damage to you or your Enrolled Dependent which results from such delay or failure to provide dental services.

NOTICES to Members or to the Employer required in the Policy will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Employer will be addressed to the Enrolled Employee or to the Employer at the last known address appearing in our records. If we receive a United States Postal Service change of address form (COA) for an Enrolled Employee, we will update our records accordingly. Additionally, we may forward notice for an Enrolled Employee to the plan administrator if we become aware that we don't have a valid mailing address for the Enrolled Employee.

Any notice to us required in the Policy may be given by mail addressed to: LifeMap Assurance Company, PO Box 1271, M/S E8L, Portland, OR 97207-1271; provided, however that any notice to us will not be deemed to have been given to and received by us until physically received by us.

WORKER'S COMPENSATION -- This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.

CONTRACT AND CLAIM PROVISIONS

IDENTIFICATION CARD -- When you, the Enrolled Employee, enroll with LifeMap Assurance Company, you will receive an identification card. It will include important information such as your identification number, your group number, and your name.

It is important to keep your identification card with you at all times. Be sure to present it to your Dentist before receiving care.

If you lose your card, or if it is destroyed, you can obtain a new one by calling our customer service department at (888) 777-9368. If coverage under the Policy terminates, your identification card will no longer be valid.

ASSIGNMENT -- No assignment by any Member of any coverage under the Policy shall be valid, except that this provision will not prohibit payment to providers of services and supplies covered by the provisions of the Policy.

RECOVERY OF BENEFITS PAID BY MISTAKE -- If a Participating Provider provides dental services to you or your Enrolled Dependent for which you or your Enrolled Dependent is not entitled, or if Benefits are provided to a person who is not eligible for Benefits under this Policy, the Participating Provider has the right to recover the Reasonable Cash Value of the Benefits provided from the Member, the person to whom Benefits were provided, or from anyone else who benefited from the payment.

CLAIMS FOR REIMBURSEMENT OF EMERGENCY TREATMENT

NOTICE OF CLAIM -- If, in the event of a Dental Emergency, the Member uses a nonparticipating dentist, claims for benefits under this Policy must be presented to Willamette Dental Group, P.C., in writing within 6 months of the date of service, or as soon as reasonably possible. The written request must include the following information: the Member's name, address, identification number; the nature of the emergency; and an itemized statement from the dentist for his or her services. Additional information, including X-rays and other data, may be requested by the Willamette Dental Group, P.C., to process the request.

All claims should be sent to the address below.

Willamette Dental Group, P.C.
Attn: Emergency Treatment Reimbursement Request
6950 NE Campus Way,
Hillsboro, OR 97124-5611

TIME PAYMENT OF CLAIMS -- Losses covered by this Policy will be paid by as soon as we receive:

1. the bills which substantiate proof of loss; and
2. any medical/dental information we request.

PAYMENT OF CLAIMS - We have the right to decide whether to pay benefits to you, to the provider of services, or to you and the provider of services jointly.

GREIVANCES AND APPEALS

GRIEVANCE PROCEDURES – To be used for a Benefit or service concern or complaint.

Most matters can be resolved with the Participating Provider's staff and Members are encouraged to first discuss matters regarding care and treatment with them. If the Member remains unsatisfied after discussion with the Participating Provider, grievance procedures are available for complaints pertaining to a denied Benefit.

A grievance is a written complaint expressing dissatisfaction with the denial of a requested Benefit. The Member should outline his or her concerns and specific request in writing. The Member may submit comments, documents, and other relevant information. Grievances must be submitted to the Participating Provider's Patient Relations Department within 180 days after the denial of Benefits.

The Patient Relations Department will review the grievance and all information submitted. You will be provided a written reply within 30 days of receipt. If additional time is needed, the Patient Relations Department will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

If the Benefit request involves:

1. A preauthorization, the Patient Relations Department will provide a written reply within 15 days of the receipt a written grievance.
2. Services deemed Experimental/Investigational, the Patient Relations Department will provide a written reply within 20 working days of the receipt a written grievance.
3. Services not yet rendered for an alleged Dental Emergency, the Patient Relations Department will provide a reply within 72 hours of the receipt a written grievance.

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

All written Grievances should be sent to the address below:

Willamette Dental Group, P.C.
Attn: Patient Relations
6950 NE Campus Way,
Hillsboro, OR 97124-5611

APPEAL PROCEDURES – To be used for a billing or eligibility concern or complaint.

If you or your Enrolled Dependent have a concern regarding billing of premium or eligibility, an appeal or request for review may be submitted (along with any additional information which would affect the situation) to us for consideration.

We will review the information submitted and you will be provided a written reply within 30 days after the appeal was received by us. If additional time is needed, we will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

All written Appeals should be sent to the address below.

LifeMap Assurance Company
Attn: Billing Supervisor
P.O. Box 1271 E8L
Portland, OR 97207-1271

DENTAL IMPLANT SURGERY BENEFIT ENDORSEMENT

This endorsement is attached to the Group Managed Care Dental Insurance Policy and Certificate of Coverage to provide Dental Implant Surgery benefits, effective October 1, 2020.

The **DENTAL BENEFITS** section is amended to add the following:

Dental Implant Surgery - The dental implant services described in this Policy are covered for Members if all of the following requirements are met:

1) A Participating Provider determines that dental implants are dentally appropriate for the Member.
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 Member follows the treatment plan prescribed by the Participating Provider.
5) The Member makes payment of amounts due.
6) The dental implant service is listed as covered in this Policy and is not otherwise limited or excluded.

If the Member's coverage ends before the completion of the dental implant services, the cost of any remaining treatment is the Member's responsibility.

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 this Policy 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

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.

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

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

The **EXCLUSIONS** section is amended to remove the following:

Dental implants, including attachment devices and their maintenance; crowns over implants.

LIFEMAP ASSURANCE COMPANY