Willamette
Dental Group

GROUP DENTAL CERTIFICATE OF COVERAGE

HIGHLINE SCHOOL DISTRICT

Policyholder Name: Washington Education Association

Effective Date: November 1, 2015

Group Number: WA304

This Certificate of Coverage ("Certificate"), including any amendments, appendices, endorsements, notices, and riders, summarizes the essential features of the Contract. This Certificate replaces and supersedes all prior certificates of coverage. Possession of this Certificate does not necessarily mean the Enrollee is covered.

If any information in the Contract is inconsistent with the provisions of this Certificate of Coverage, the Certificate of Coverage will control.

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

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Section 1 Definitions

1.1 **"Benefit Administrator"** means Aon Hewitt, the entity designated by the Policyholder to perform duties including, but not limited to, issuance of periodic eligibility and payroll reports to the Participating Employer Group, providing periodic eligibility files to the Company, periodic Premium collection, and disbursement of Premium to the Company.

1.2 **"Child"** means a child of the Subscriber (or Subscriber's spouse or Subscriber's domestic partner), including a natural child; stepchild; adopted child; child for whom the Subscriber (or Subscriber's spouse or Subscriber's domestic partner) has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child; or child for whom the Subscriber (or Subscriber's spouse or Subscriber's domestic partner) has court-appointed legal guardianship. Child also includes a child for whom the Subscriber (or Subscriber's spouse or Subscriber's domestic partner) is required to provide dental coverage by a legal qualified medical child support order (QMCSO).

1.3 **"Company"** means Willamette Dental of Washington, Inc.

1.4 **"Contract"** means the agreement between the Company and the Policyholder. The Contract, including the Application for Group Dental Coverage, appendices, exhibits, riders, amendments, and endorsements, if any, constitutes the entire contract between the parties and supersedes all prior agreements between the parties.

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

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

1.7 **"Dental Emergency"** means an acute infection, traumatic damage to the oral cavity, or discomfort that cannot be controlled by non-prescription pain medication.

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

1.9 **"Denturist"** means a person licensed to practice denturism in the state where treatment is provided.

1.10 **"Dependent"** means a Subscriber's spouse, domestic partner, or Child, who is eligible and enrolled for coverage.

1.11 **"Enrollee"** means a Subscriber or a Dependent.

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

- Whether the services are in general use in the dental community in the State of Washington;

- Whether the services are under continued scientific testing and research;
- Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
- Whether the services are proven safe and effective.

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

1.14 **"Non-Participating Provider"** means a Dentist or Denturist, who is not employed by or under contract with the Company or Participating Provider to provide dental services.

1.15 **"Participating Employer Group"** means any division of the Washington Public Schools, the WEA and its affiliates, or bargaining unit or other bona fide employee classification of an eligible employer whose participation under the Contract has been approved in writing by the Policyholder and the Company.

1.16 **"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 appendices for Covered Services.

1.17 **"Plan Administrator"** means the Participating Employer Group or the entity designated by the Participating Employer Group, to perform duties including, but not limited to, maintaining employee eligibility records with the Benefit Administrator and remittance of monthly Premium payment to the Benefit Administrator.

1.18 **"Policyholder"** means Washington Education Association (WEA).

1.19 **"Premium"** means the net monthly payment the Plan Administrator must pay to the Company through the Benefit Administrator, including any Subscriber contributions, for coverage of each Enrollee.

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

1.21 **"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.

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

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

1.24 "Subscriber" means an individual employee covered under a negotiated labor agreement, or a bona fide employee classification of a Participating Employer Group, who is eligible and enrolled for coverage.

Section 2 Eligibility and Enrollment

2.1 Eligible Employees.

2.1.1 Active employees must work the minimum number of hours required by the Participating Employer Group to be eligible for coverage. Employees become eligible for coverage on the first day of the calendar month following the Participating Employer Group's payment of the monthly dues.

2.1.2 School board members are not eligible for coverage under the Contract unless the school board member is on the payroll of the school district and meets the eligibility requirements. School board members who receive compensation for their services as board members are not considered employees for this purpose.

2.2 Eligible Family Members. The eligible employee must enroll in order to enroll eligible family members. The Plan Administrator, Benefit Administrator, or Company may require proof of Dependent eligibility periodically.

2.2.1 A spouse, a domestic partner who has entered into a state registered domestic partnership with the Subscriber, or a domestic partner who meets the requirements of and has completed a "Declaration of Domestic Partnership" is eligible for coverage as a Dependent.

2.2.2 The Subscriber's, spouse's, or domestic partner's married or unmarried Child is eligible for coverage as a Dependent to age 26.

2.2.3 A Subscriber's, spouse's, or domestic partner's Child is eligible as a Dependent beyond the limiting age if all of the following conditions are met:

1. The Child is and continues to be incapable of self-sustaining employment by reason of a developmental disability or physical handicap.
2. The Child is and continues to be chiefly dependent upon the Subscriber (or Subscriber's spouse or Subscriber's domestic partner) for support and maintenance.
3. Proof of such incapacity and dependency is provided to the Company no later than 31 days after the Child's attainment of the limiting age or during the Subscriber's initial enrollment period. Proof may be requested annually.

2.3 Initial Enrollment Period. The eligible employee must complete the applicable enrollment requirements as authorized by the Policyholder for himself/herself and any eligible family members to be covered no later than 31 days after attaining initial eligibility. Please contact the Plan Administrator for specific enrollment instructions. Coverage begins on the first day of the month following or coinciding with the date the eligible employee attains initial eligibility. Eligible employees and their eligible family members who do not enroll during the initial enrollment period may enroll only during an open enrollment period or a special enrollment period.

2.4 Open Enrollment Period. Eligible employees and their eligible family members may enroll during the annual open enrollment period by completing the applicable enrollment requirements as authorized by the Policyholder. An Enrollee for whom coverage is terminated voluntarily must wait until the next open enrollment period to enroll, unless a qualifying event triggers a special enrollment opportunity. Coverage will begin on the anniversary date of the Contract. A Subscriber may terminate a Dependent's coverage only during open enrollment, unless there is a qualifying event.

2.5 Special Enrollment Period. A special enrollment period is granted for employees and their eligible family members after the qualifying events described below.

2.5.1 Birth or Adoption. Eligible employees and their eligible family members may enroll following the birth or adoption of an eligible Child by completing the applicable enrollment requirements as authorized by the Policyholder. Coverage will begin on the newborn Child's date of birth or on the adopted Child's date of placement for adoption. Coverage for an enrolled newborn Child includes, but is not limited to benefits for Covered Services provided for treatment of congenital anomalies from the date of birth.

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 completing the applicable enrollment requirements as authorized by 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 completing the applicable enrollment requirements as authorized by 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 eligible employee must complete the applicable enrollment requirements as authorized by the Policyholder no later than 63 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 the event date.

Section 3 Premium Provisions

3.1 **Payment of Premium.** The Premium for each Enrollee is due on or before the first day of each month. The payment of the Premium for all Enrollees must be submitted to the Company in a single lump sum. A 70-day grace period is granted for payment of the Premium. If the Premium is unpaid at the end of the grace period, the Company will be released from all further obligations under the Contract. Only Enrollees for whom the Company has received the Premium payment 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.

Section 4 Dental Coverage

4.1 **Agreement to Provide Covered Services.** The Company shall provide benefits for prescribed Covered Services listed as covered in the appendices. Covered Services must be provided by the Participating Provider, except as specified otherwise. All Covered Services are expressly subject to the Copayments, exclusions, limitations, and all other provisions of the Contract.

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

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

4.3 **Dental Emergency.**

4.3.1 Participating Providers will provide treatment for Dental Emergencies during office hours. The Company will provide benefits for Covered Services rendered by Participating Providers for treatment of a Dental Emergency. The Enrollee is responsible for payment of the General Office Visit Copayment for visits for treatment of a Dental Emergency, in addition to Service Copayments, if any. If the Participating Providers' offices are closed, the Enrollee may access after-hours telephonic clinical assistance by calling the Appointment Center at 1.855.4DENTAL (1-855-433-6825). There is no cost for accessing after-hours telephonic clinical assistance.

4.3.2 The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider office. The Company will reimburse the Enrollee up to the out of area emergency reimbursement amount less any Copayments specified in Appendix A for the cost of the Covered Services. The Enrollee must submit a written request for reimbursement to the Company no later than 1 year after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The benefit for out of area Dental Emergency treatment will not be provided if the requested information is not received.

4.4 **Dual Coverage.** A Subscriber may not be covered more than once as a Subscriber under the Contract.

4.5 **Coordination of Benefits.** This coordination of benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below.

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

4.5.2 Definitions

a. A Plan is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.
    1. Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    2. Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.
    3. Each contract for coverage under 1 or 2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
b. This Plan means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits 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 dental care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that This Plan would have paid if it were the Primary Plan. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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

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

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

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

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

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

b. Except as provided in subsection c, a Plan that does not contain a coordination of benefits provision that is consistent with state regulation regarding coordination of benefits is always primary unless the provisions of both Plans state that the complying Plan is primary.
c. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
d. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
e. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Nondependent or dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
    2. Dependent Child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent Child is covered by more than one Plan the order of benefits is determined as follows:
        (a) For a dependent Child whose parents are married or are living together, whether or not they have ever been married: the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
        (b) For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            (i) If a court decree states that one of the parents is responsible for the dependent Child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
            (ii) If a court decree states one parent is to assume primary financial responsibility for the dependent Child but does not mention responsibility for dental care expenses, the Plan of the parent assuming financial responsibility is primary;
            (iii) If a court decree states that both parents are responsible for the dependent Child's dental care expenses or dental care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent Child, the provisions of subsection (a) above determine the order of benefits; or

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

- The Plan covering the Custodial Parent, first;
- The Plan covering the spouse of the Custodial Parent, second;
- The Plan covering the noncustodial parent, third; and then
- The Plan covering the spouse of the noncustodial parent, last.

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

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

4.5.4 Effect on the Benefits of This Plan. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim cannot be less than the same Allowable Expense as the Secondary Plan would have paid if it was the Primary Plan. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

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

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

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

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

Section 5 Exclusions & 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 performed or initiated prior to the effective date of coverage under the Contract, including the following:

a. Endodontic services and prosthodontic 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 Dental implants, including attachment devices, maintenance, and dental implant-related services.

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

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

5.1.6 Experimental or Investigational services and related exams or consultations.

5.1.7 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.

5.1.8 Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees, except as covered under Section 5.2.5.

5.1.9 Maxillofacial prosthetic services.

5.1.10 Orthodontic procedures or other orthodontic treatment, including but not limited to the extraction of permanent teeth for tooth guidance procedures, procedures to address tooth movement, and correction of malocclusion except if the Enrollee is eligible for orthodontia benefits under Appendix B.

5.1.11 Personalized restorations.

5.1.12 Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.

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

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

5.1.15 Removal of tumor, cyst, or torus; or biopsy of soft or hard tissue.

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

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

5.1.18 Replacement of sound restorations.

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

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

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

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 any condition occurring during or resulting from military service or a declared or undeclared war.

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

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

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

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

5.1.28 Services that would not have been provided or that the Enrollee would have had no obligation to pay for in the absence of the Contract.

5.1.29 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. In the event the Enrollee elects a service that is more costly than the service the Participating Provider has approved, the Enrollee is responsible for the Copayment for the recommended covered service plus the cost differential between the Reasonable Cash Value of the recommended service and the Reasonable Cash Value of the more costly requested service.

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

5.2.3 Endodontic Retreatment.

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

5.2.4 General Anesthesia. General anesthesia is covered with the Copayments specified in Appendix A only if the following criteria are met:

a. It is performed in a dental office;
b. It is provided in conjunction with a Covered Service; and
c. The Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically handicapped.

5.2.5 Hospital Setting. The services provided by a Dentist in a hospital setting are covered if the following criteria are met:

a. A hospital or similar setting is medically necessary;
b. The services are authorized in writing by the Participating Provider;
c. The services provided are the same services that would be provided in a dental office; and
d. The applicable Copayments are paid.

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

a. A tooth within an existing denture or bridge is extracted;
b. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or

c. The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under the Contract, and replacement by a permanent denture is necessary.

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

5.2.8 Occlusal Guard Replacements. The replacement of a lost occlusal guard is covered only once in a 2-year period. Repair or replacement of a broken or damaged occlusal guard is covered as needed.

Section 6 Termination Provisions

6.1 **Termination of Coverage for Participating Employer Groups.** The Participating Employer Group shall promptly notify all Enrollees of the termination of the availability of coverage under the Contract. Coverage under the Contract shall terminate for a Participating Employer Group on the earliest of the following:

6.1.1 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.

6.1.2 On the date of written notice, if there is legal cause for termination.

6.1.3 On the date the Contract is terminated.

6.2 **Return of Advance Payment of Premium**. If the Company receives early payment of Premiums prior to the termination of the Contract, the Company will refund the unearned Premium. Prior written notice of the intent to terminate in accordance with the Contract must be provided. The Plan Administrator must promptly notify all Enrollees of the termination of the Contract. If an Enrollee receives Benefits after termination or for any period for which Premium remains unpaid, the Company is entitled to recover the Reasonable Cash Value of the Benefits provided in the form of services for that period.

6.3 **Termination of Coverage for Enrollees.** Coverage for an Enrollee will terminate on the earliest of the following:

6.3.1 On the date the Contract is terminated.

6.3.2 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.

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

6.3.4 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 a Participating Provider, threats or abuse towards the Participating Provider, office staff or other patients, or nonpayment of Copayments. The Participating Provider reserves the right to refer the Enrollee to another Participating Provider location reasonably accessible to the Patient if the Participating Provider has documented an inability to establish or maintain a patient/provider relationship.

6.3.5 If coverage terminates for the Subscriber, it will terminate for the Dependents covered under the Subscriber.

6.4 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 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.

6.5 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.

6.6 Continuation Rights. The Plan Administrator agrees to notify all Enrollees of their right to continuation of coverage and administer continuation of coverage in accordance with state and federal laws.

6.6.1 Federal or State Mandated Continuation Coverage. Coverage for Enrollees may continue during a leave of absence taken in accordance with any federally-mandated or state-mandated leave act or law.

6.6.2 COBRA. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, certain circumstances, called qualifying events, give Subscribers and some Dependents the right to continue coverage beyond the time it would ordinarily end. Federal law governs COBRA continuation rights and obligations. The Policyholder is responsible for administering COBRA continuation coverage.

a. When the Subscriber's employment terminates for reasons other than gross misconduct or experiences a reduction in hours, the Subscriber and/or the Dependents may continue coverage generally for up to 18 months, or until covered under another group dental plan, by self-paying the required premium.
b. If a Dependent experiences a second qualifying event during the 18-month continuation period, the Dependent will be eligible to continue coverage for up to 36 months from the date of the first qualifying event.
c. If a Dependent no longer meets the eligibility requirements due to death, divorce or legal separation of the Subscriber, or does not meet the age requirement for children, coverage may continue for up to 36 months, or until the Dependent is covered under another group plan (unless the new plan does not cover a pre-existing condition of the dependent), by self-paying the required premium. The Enrollees are responsible for notifying the Plan Administrator of ineligibility or the loss of coverage due to divorce or legal separation or if a child becomes ineligible for coverage as a Dependent.
d. Disabled Enrollees, who are disabled at the time the Subscriber terminates employment or has a reduction in hours or within 60 days thereafter, may be eligible for an additional 11 months of continuation coverage subject to certain conditions. The total continuation coverage period will not exceed 29 months.
e. Generally, COBRA participants lose coverage when they become eligible under another group plan. However, if the new plan has pre-existing conditions, limitations or exclusions, affected individuals may continue coverage under the former plan until the pre-existing condition(s) is no longer limited or the continuation coverage period ends whichever occurs first.

f. Continuation of coverage may be ended according to the law for any of the following reasons:
    1. The Participating Employer Group or the Policyholder no longer provides group dental coverage to any employees;
    2. The premium for continuation coverage is not paid, or not paid on time, as provided by law;
    3. The Enrollee becomes covered under another group dental plan; except as explained above regarding pre-existing conditions; or
    4. The Subscriber becomes entitled to Medicare.

6.6.3 Labor Disputes. If a Subscriber's compensation is suspended or terminated as the result of a strike, lockout, or other labor dispute, coverage may continue for up to 6 months if the Subscriber pays the Premium to the Participating Employer Group on or before the date Premium is due. This period of coverage will not extend any other period of continued coverage available under the Contract. The Participating Employer Group shall notify the Subscriber in writing of the right to continue coverage. The Premium rate during a work stoppage is equal to the Premium rate in place before the work stoppage. The Company may change the Premium rates according to the provisions of the Contract. Coverage will terminate on the earliest of the following events:

a. The last day of the month for which the Premium is paid, if the Premium is unpaid at the end of the grace period;
b. The last day of the 6th month following the date the work stoppage began;
c. The last day of the month in which the Subscriber ceases to be eligible; or
d. The date of termination of the Contract.

6.6.4 Leave of Absence.

a. Coverage may be continued during a temporary, Participating Employer Group approved leave of absence or sabbatical for up to 18 months.
b. The leave of absence begins at the end of the last month of coverage paid from fringe benefits earned during active employment. If a Subscriber does not elect continued coverage at the beginning of the leave of absence, the Enrollees must wait to enroll when the Subscriber returns to active employment.
c. Participating Employer Group-approved leave of absences beyond 18 months do not entitle the Subscriber or Dependents to extend coverage beyond 18 months under this Section.
d. If the leave of absence is extended beyond 18 months, the Subscriber may be eligible for an additional 18 months of COBRA. The Subscriber must elect coverage under COBRA within 60 days after coverage under this leave of absence provision terminates. COBRA is also available if the Subscriber does not return to active employment after a Participating Employer Group approved leave or is granted a subsequent Participating Employer Group-approved leave of absence.
e. The maximum length of extended coverage is 36 months: a maximum of 18 months continued coverage during a leave of absence and a maximum of 18 months of continued coverage through COBRA.

6.6.5 Reduction in Force. If the Subscriber's employment is suspended or terminated due to a reduction in force, coverage for Enrollees may continue on a self-pay basis for a period of up to 12 months from the date the Subscriber's employment was terminated or suspended. This provision will not apply if the Subscriber is eligible for coverage under COBRA.

6.6.6 Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage will terminate for the Subscriber and Dependent if the Subscriber is called to active duty by any of the armed forces of the United States of America. The Subscriber may request to continue coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the Subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active Subscribers. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

a. If the Subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day the Subscriber returns to active employment with the Participating Employer Group if the Subscriber is released under honorable conditions, but only if the Subscriber returns to active employment:
    1. On the first full business day following completion of the Subscriber's military service for a leave of 30 days or less;
    2. Within 14 days of the Subscriber completing his or her military service for a leave of 31 to 180 days; or
    3. Within 90 days of the Subscriber completing his or her military service for a leave of more than 180 days.
b. Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.
c. When coverage under the Contract is reinstated, all provisions and limitations of the Contract will apply to the extent that they would have applied if the Subscriber had not taken military leave and his or her coverage had been continuous under the Contract. There will be no additional eligibility waiting period. This does not provide coverage for any illness or injury caused or aggravated by the Subscriber's military service, as determined by the VA. For complete information regarding rights under the Uniformed Services Employment and Reemployment Rights Act, the Subscriber should contact his or her employer.

6.6.7 If coverage ends because continuation rights expire, coverage may reinstate pursuant to applicable federal or state law, if the Enrollee satisfies the applicable eligibility and enrollment requirements.

6.7 Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Anyone terminated for good cause or failure to make timely payment is not eligible for an extension of benefits.

6.7.1 Crowns or Bridges. Adjustments for crowns or bridges will be covered for up to 6 months after placement if the final impressions are taken prior to termination and the crown or bridge is placed no later than 60 days after termination.

6.7.2 Removable Prosthetic Devices. Adjustments for removable prosthetic devices will be covered for up to 6 months after placement if final impressions are taken prior to termination and the prosthesis is delivered no later than 60 days after termination. Laboratory relines are not covered after termination.

6.7.3 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.

6.7.4 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.

6.7.5 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 waiving any right to reimbursement or subrogation.

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

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

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

a. Provide the Company and Participating Provider with the name and address of the parties liable, all facts known concerning the injury, and other information as reasonably requested;
b. Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Company's and Participating Provider's subrogation rights; and
c. Take all necessary action to seek and obtain recovery to reimburse the Company and Participating Provider for the Reasonable Cash Value of the Covered Services.

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

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

7.2 Complaints, Grievances, and Appeals.

7.2.1 Complaints.

a. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider and Participating Provider's staff. Most matters can be resolved with the Participating Provider and Participating Provider's staff.
b. If the Enrollee requests a specific service, the Participating Provider will use his/her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.
c. Enrollees may also contact the Member Services Department with questions or complaints at:

Willamette Dental of Washington, Inc.
Attn: Member Services

6950 NE Campus Way
Hillsboro, OR 97124-5611
1.855.4DENTAL (1-855-433-6825)

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

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. An appeal must be submitted in writing to the Member Services Department no later than 180 days after the date of the denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information. The appeal will be evaluated by someone who was not involved in the initial denial of the grievance.
b. The Company will review the appeal and all information submitted. The Company will provide a written reply no later than 60 days after the receipt of a written request for an appeal. If the appeal involves:
    1. A preauthorization, the Company will provide a written reply no later than 30 days after the receipt of a written request for an appeal.
    2. Services deemed Experimental or Investigational, the Company will provide a written reply no later than 20 working days after the receipt of a written request for an appeal.
    3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours of the receipt of a written request for an appeal.

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

7.2.4 WEA Appeal Procedure. If the claim is not resolved to the satisfaction of all parties involved, it may be appealed by the Enrollee or the Enrollee's authorized representative to the WEA Benefit Services Advisory Board ("Board") in accordance with the WEA Procedure for Benefit Services Claim Review. The Board shall conduct a hearing at which time the Enrollee shall be entitled to present his or her opinion and any evidence in support thereof. After reviewing testimony and documentation from all parties involved, the Board shall issue a written decision affirming, modifying, or setting aside the former action. Furthermore, any costs incurred in connection with a claims appeal such as attorney's fees or travel expenses are not covered, nor will the Board have access to dental information without the written permission of the Enrollee. For more information on the WEA claim review, contact Aon Consulting at (206) 467-4646.

7.3 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 process for an appeal submitted by a representative of the Enrollee will not commence until this authorization is received. If the written authorization is not received by the Company, the grievance or appeal will be closed.

7.4 Rights Not Transferable. The benefits of the Contract are not transferable.

7.5 Modification of Contract. Modification of the Contract becomes binding when it is in writing and signed by an officer of the Company.

7.6 Force Majeure. If the provision of benefits available under the Contract is delayed or rendered impractical due to circumstances not within the Company's reasonable control, including but not limited to, major disaster, labor dispute, complete or partial destruction of facilities, disability of a material number of the Participating Providers, or similar causes, the Company and its affiliates shall not have any liability or obligation on account of such delay or failure to provide benefits, except to refund the amount of the unearned advanced Premium held by the Company on the date such event occurs. The Company is required to make a good-faith effort to provide benefits, taking into account the impact of the event.

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

7.8 Waiver and Severability. If the Company does not enforce a provision of the Contract, it will not constitute a waiver of that or any other provision at any time in the future. If any provision of the Contract is declared unenforceable by a court of having jurisdiction, the provision is ineffective only to the extent declared unenforceable. The remainder of the provision and all other provisions of the Contract shall continue in full force and effect.

7.9 Notices. Notices required by the Contract must be in writing and sent by first-class United States Mail, overnight delivery service, personal delivery, or electronic mail. Notices are deemed given when deposited in the United States mail, delivered in person, or sent via email. Notices will be addressed to the Policyholder at his/her last address appearing in the records of the Company, or addressed to the Company at: 6950 NE Campus Way, Hillsboro, OR 97124-5611.

7.10 Clerical Error. Clerical errors will not invalidate coverage or extend coverage. Upon discovery of an error, the Premium, Copayments, or fees will be adjusted. The Company may revise any contractual document issued in error.

7.11 Statements. In the absence of fraud, statements made by the Policyholder, Participating Employer Group, or an insured person are representations which the Company may rely upon. Statements made for the purpose of acquiring coverage will not void the coverage or reduce benefits, unless contained in a written instrument signed by the Policyholder, Benefit Administrator, Participating Employer Group, or the insured person.

Appendix A - Schedule of Covered Services and Copayments

Plan 1

Office Visit Copayments

General Office Visit Copayment $15
Specialist Office Visit Copayment..... $15

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	Extraoral - first radiographic image	$0
D0260	Extraoral - each additional 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 space maintainer	$0
D1555	Removal of fixed space maintainer	$0
2. Restorative Services		
D2140	Amalgam - 1 surface, primary or permanent	$0
D2150	Amalgam - 2 surfaces, primary or permanent	$0
D2160	Amalgam - 3 surfaces, primary or permanent	$0

D2161	Amalgam - 4 or more surfaces, primary or permanent	$0
D2330	Resin - based composite - 1 surface, anterior	$0
D2331	Resin - based composite - 2 surfaces, anterior	$0
D2332	Resin - based composite - 3 surfaces, anterior	$0
D2335	Resin - based composite - 4 or more surfaces involving incisal angle (anterior)	$0
D2390	Resin - based composite crown, anterior	$0
D2391	Resin - based composite - 1 surface, posterior	$0
D2392	Resin - based composite - 2 surfaces, posterior	Primary tooth: $0 Permanent tooth: $52
D2393	Resin - based composite - 3 surfaces, posterior	Primary tooth: $0 Permanent tooth: $52
D2394	Resin - based composite - 4 or more surfaces, posterior	Primary tooth: $0 Permanent tooth: $52
D2510	Inlay - metallic - 1 surface	$50
D2520	Inlay - metallic - 2 surfaces	$50
D2530	Inlay - metallic - 3 or more surfaces	$50
D2542	Onlay - metallic - 2 surfaces	$50
D2543	Onlay - metallic - 3 surfaces	$50
D2544	Onlay - metallic - 4 or more surfaces	$50
D2610	Inlay - porcelain/ceramic - 1 surface	$50
D2620	Inlay - porcelain/ceramic - 2 surfaces	$50
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$50
D2642	Onlay - porcelain/ceramic - 2 surfaces	$50
D2643	Onlay - porcelain/ceramic - 3 surfaces	$50
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$50

3. Crowns

D2710	Crown - resin based composite (indirect)	$50
D2740	Crown - porcelain/ceramic substrate	$50
D2750	Crown - porcelain fused to high noble metal	$50
D2752	Crown - porcelain fused to noble metal	$50
D2780	Crown - ¾ cast high noble metal	$50
D2782	Crown - ¾ cast noble metal	$50
D2792	Crown - full cast noble metal	$50
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2932	Prefabricated resin crown	$0
D2933	Prefabricated stainless steel crown with resin window	$0
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2954	Prefabricated post and core in addition to crown	$0
D2955	Post removal	$0
D2957	Each additional prefabricated post - same tooth	$0
D2970	Temporary crown (fractured tooth)	$0
D2975	Coping	$0
D2980	Crown repair necessitated by restorative material failure	$0

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)	$0
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$0
D3330	Endodontic therapy, molar (excluding final restoration)	$0
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$0
D3347	Retreatment of previous root canal therapy - bicuspid	$0
D3348	Retreatment of previous root canal therapy - molar	$0
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3352	Apexification/recalcification - interim medication replacement	$0
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3410	Apicoectomy - anterior	$0
D3421	Apicoectomy - bicuspid (first root)	$0
D3425	Apicoectomy - molar (first root)	$0
D3426	Apicoectomy - (each additional root)	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$0
D3950	Canal preparation and fitting of a preformed dowel or post	$0

5. Periodontics

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4240	Gingival flap procedures, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4249	Clinical crown lengthening - hard tissue	$0
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4263	Bone replacement graft - first site in quadrant	$0
D4264	Bone replacement graft - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$0
D4273	Subepithelial connective tissue graft procedures, per tooth	$0
D4274	Distal proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$0
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$0
D4341	Periodontic scaling and root planing - 4 or more teeth per quadrant	$0
D4342	Periodontic scaling and root planing - 1 to 3 teeth per quadrant	$0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$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	$50
D5120	Complete denture - mandibular	$50
D5130	Immediate denture - maxillary	$50
D5140	Immediate denture - mandibular	$50
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$50
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$50
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$50
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$50
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$50
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5510	Repair broken complete denture base	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5610	Repair resin denture base	$0
D5620	Repair cast framework	$0
D5630	Repair or replace broken clasp	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0
D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (laboratory)	$0
D5751	Reline complete mandibular denture (laboratory)	$0
D5760	Reline maxillary partial denture (laboratory)	$0
D5761	Reline mandibular partial denture (laboratory)	$0
D5810	Interim complete denture (maxillary)	$25
D5811	Interim complete denture (mandibular)	$25
D5820	Interim partial denture (maxillary)	$25
D5821	Interim partial denture (mandibular)	$25
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5863	Overdenture - complete maxillary	$50
D5864	Overdenture - partial maxillary	$50
D5865	Overdenture - complete mandibular	$50
D5866	Overdenture - partial mandibular	$50
D5986	Fluoride gel carrier	$0

7. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$50
D6240	Pontic - porcelain fused to high noble metal	$50
D6241	Pontic - porcelain fused to predominantly base metal	$50
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$50

D6720	Crown - resin with high noble metal	$50
D6750	Crown - porcelain fused to high noble metal	$50
D6780	Crown - ¾ cast high noble metal	$50
D6790	Crown - full cast high noble metal	$50
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

8. Oral Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$0
D7220	Removal of impacted tooth - soft tissue	$0
D7230	Removal of impacted tooth - partially bony	$0
D7240	Removal of impacted tooth - completely bony	$0
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$0
D7250	Surgical removal of residual tooth roots (cutting procedure)	$0
D7260	Oroantral fistula closure	$0
D7261	Primary closure of a sinus perforation	$0
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$0
D7280	Surgical access of an unerupted tooth	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$0
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$0
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$0
D7510	Incision & drainage of abscess - intraoral soft tissue	$0
D7520	Incision & drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$0
D7670	Alveolus - closed reduction, may include stabilization of teeth	$0
D7910	Suture of recent small wounds up to 5 cm	$0
D7911	Complicated suture - up to 5 cm	$0
D7953	Bone replacement graft for ridge preservation - per site	$0
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another	$0
D7970	Excision of hyperplastic tissue - per arch	$0
D7971	Excision of pericoronal gingiva	$0
	Orthognathic surgery for treatment of congenital anomalies for enrolled Children under age 19 - Subject to a lifetime benefit maximum of $3,000	75% of charges

9. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$250
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$0

D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital or ambulatory surgical center call	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$0
D9910	Application of desensitizing medicament	$0
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9940	Occlusal guard, by report	$0
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$0
D9970	Enamel microabrasion	$0
	Out of Area Emergency Reimbursement (The Enrollee is reimbursed up to $500 per visit.)	All charges in excess of $500

Appendix B - Orthodontic Treatment

Plan 6 – For All Enrollees

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. 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.

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

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

e. The Enrollee must follow the post-treatment plan and keep all appointments after the Enrollee is de-banded to avoid additional Copayments.

f. If coverage for orthodontic services terminates prior to completion of orthodontic treatment, Benefits will continue through the end of the month and the Copayment may be prorated. The cost of services necessary to complete treatment will be based on the Reasonable Cash Value after coverage terminates.

2. Pre-Orthodontic Service Copayment.

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

3. Orthodontic Service Copayment.

Comprehensive Orthodontic Service Copayment: $2,000
The following orthodontic procedures are Covered Services under this benefit:
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8691 Repair of orthodontic appliance

Appendix C - Temporomandibular Joint Disorder Treatment

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

1. **Benefits.** Benefits for treatment of TMJ are limited to a yearly benefit maximum of $1,000 and a lifetime benefit maximum of $5,000.

2. **Limitations and Exclusions.**

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

WILLAMETTE DENTAL
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We use and disclose protected health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your protected health information to provide, manage and coordinate your dental coverage.

Payment: We may use and disclose your protected health information to conduct payment related activities, such as determinations of eligibility and coverage, billing, administration and coordination of benefit payments.

Healthcare Operations: We may use and disclose your protected health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, establishment of premium rates; activities relating to the creation, renewal or replacement of a dental plan; performing quality assessment and improvement activities; licensing or accreditation activities; responding to and resolving complaints and appeals; plan communications; and facilitating your enrollment in and renewal of your dental plan and value-added services. We will not use or disclose any of your protected health information that contains genetic information for underwriting purposes.

To You, Your Personal Representatives and Plan Sponsor: We must disclose your protected health information to you, as described in the Member Rights section of this Notice, and to a parent of a minor under the age of consent or legal guardian as necessary to help with your healthcare or with payment. We may disclose your protected health information to the sponsor of your dental plan.

Family and Friends: We may disclose protected health information about you to your family members or friends if we obtain your verbal authorization to do so, or if we give you an opportunity to object and you do not object. We also may disclose protected health information to your family or friends if we can infer from the circumstances, based on our reasonable judgment, that you would not object, for example if your spouse is a covered member with you under your dental plan.

Marketing Health-Related Services: We may use or disclose your protected health information for marketing purposes with your written authorization.

Required by Law: We may use or disclose your protected health information when we are required to do so by federal, state or local law or legal process, for example, subpoena, court order, administrative order, warrant, or summons; and pursuant to workers' compensation laws.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your protected health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Plans in Oregon – Willamette Dental Insurance, Inc.
Plans in Washington – Willamette Dental of Washington, Inc.
Plans in Idaho – Willamette Dental of Idaho, Inc.

Plan Sponsors: If your coverage is through an employer sponsored dental plan, we may disclose certain protected health information to the plan sponsor or its authorized representative(s) to perform plan administration functions.

Governmental Officials and Law Enforcement: We may disclose to authorized governmental officials protected health information required for lawful investigation; military authorities, the protected health information of Armed Forces personnel; and a correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Authorizations: Other uses and disclosures of your protected health information will be made only with your, or your Personal Representative's, written authorization. You may revoke such authorization at any time by written request, but we cannot take back any uses or disclosures already made with your permission.

MEMBER RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. If you request an alternative format that we can practicably provide, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before September 23, 2007. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request in writing that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how account information will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Breach Notification: You have the right to receive notice if the security of your unsecured protected health information is breached.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy of this Notice upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your protected health information. You will not be penalized in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Member Rights Information:
Willamette Dental Member Services
6950 NE Campus Way
Hillsboro, Oregon 97124
(855) 433-6825, Option 3

Complaints:
Willamette Dental Privacy Officer
6950 NE Campus Way
Hillsboro, Oregon 97124
(855) 433-6825

Plans in Oregon – Willamette Dental Insurance, Inc.
Plans in Washington – Willamette Dental of Washington, Inc.
Plans in Idaho – Willamette Dental of Idaho, Inc.