Willamette Dental Group

GROUP DENTAL OUTLINE AND CERTIFICATE OF COVERAGE

Policyholder Name: Canyon County

Effective Date: January 1, 2020

Contract Number: ID39

This is a group managed care dental contract underwritten by Willamette Dental of Idaho, Inc.

Read Your Certificate Carefully.

This outline and certificate of coverage provides a very brief description of the important features of the Contract. This is not the insurance contract and only the actual contract provisions will control. The Contract itself sets forth in detail the rights and obligations of you, the Policyholder and the Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Willamette Dental of Idaho, Inc.
Administrative Office:
6950 NE Campus Way
Hillsboro, OR 97124-5611

First In Proactive Dental Care

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Schedule of Covered Services and Cost-Sharing

Please remember that all Covered Services are subject to the definitions, limitations, and exclusions in the Contract and are covered only when dentally necessary.

For Covered Services From a Participating Provider or Under a Referral from a Participating Provider

		ENROLLEE PAYS
Office Visit Copayments		
General Office Visit Copayment		$15
Specialist Office Visit Copayment		$30
Diagnostic and Preventive Services		
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under 3 years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed & extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical-first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	Cephalometric radiographic image	$0
D0350	2D oral/facial photographic image obtained intraorally or extraorally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0

D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cement or re-bond space maintainer	$0
D1555	Removal of fixed space maintainer	$0

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	$0
D2393	Resin - based composite - 3 surfaces, posterior	$0
D2394	Resin - based composite - 4 or more surfaces, posterior	$0
D2510	Inlay - metallic - 1 surface	$75
D2520	Inlay - metallic - 2 surfaces	$75
D2530	Inlay - metallic - 3 or more surfaces	$75
D2542	Onlay - metallic - 2 surfaces	$75
D2543	Onlay - metallic - 3 surfaces	$75
D2544	Onlay - metallic - 4 or more surfaces	$75
D2610	Inlay - porcelain/ceramic - 1 surface	$75
D2620	Inlay - porcelain/ceramic - 2 surfaces	$75
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$75
D2642	Onlay - porcelain/ceramic - 2 surfaces	$75
D2643	Onlay - porcelain/ceramic - 3 surfaces	$75
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$75

Crowns

D2710	Crown - resin based composite (indirect)	$75
D2740	Crown - porcelain/ceramic	$75
D2750	Crown - porcelain fused to high noble metal	$75
D2782	Crown - ¾ cast noble metal	$75
D2792	Crown - full cast noble metal	$75
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

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)	$60
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$90
D3330	Endodontic therapy, molar (excluding final restoration)	$120
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	$60
D3347	Retreatment of previous root canal therapy - premolar	$90
D3348	Retreatment of previous root canal therapy - molar	$120
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$120
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	$60
D3421	Apicoectomy - premolar (first root)	$90
D3425	Apicoectomy - molar (first root)	$120
D3426	Apicoectomy - (each additional root)	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$120
D3920	Hemisection (including any root removal), not including root canal therapy	$120
D3950	Canal preparation and fitting of a preformed dowel or post	$0

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 - retained natural tooth - first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$0
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$0
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$0
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$0
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in the same graft site	$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

Prosthodontics - Removable

D5110	Complete denture - maxillary	$150
D5120	Complete denture - mandibular	$150
D5130	Immediate denture - maxillary	$150
D5140	Immediate denture - mandibular	$150
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$150
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$150
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$150
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$150
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$150
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5511	Repair broken complete denture base, mandibular	$0
D5512	Repair broken complete denture base, maxillary	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5611	Repair resin partial denture base, mandibular	$0
D5612	Repair resin partial denture base, maxillary	$0
D5621	Repair cast partial framework, mandibular	$0
D5622	Repair cast partial framework, maxillary	$0
D5630	Repair or replace broken clasp – per tooth	$0
D5640	Replace broken teeth - per tooth	$0

D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture – per tooth	$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)	$75
D5811	Interim complete denture (mandibular)	$75
D5820	Interim partial denture (maxillary)	$75
D5821	Interim partial denture (mandibular)	$75
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5863	Overdenture - complete maxillary	$150
D5864	Overdenture - partial maxillary	$150
D5865	Overdenture - complete mandibular	$150
D5866	Overdenture - partial mandibular	$150
D5986	Fluoride gel carrier	$0

Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$75
D6240	Pontic - porcelain fused to high noble metal	$75
D6241	Pontic - porcelain fused to predominantly base metal	$75
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$75
D6720	Retainer crown - resin with high noble metal	$75
D6750	Retainer crown - porcelain fused to high noble metal	$75
D6780	Retainer crown - ¾ cast high noble metal	$75
D6790	Retainer crown - full cast high noble metal	$75
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$75
D7220	Removal of impacted tooth - soft tissue	$75
D7230	Removal of impacted tooth - partially bony	$75
D7240	Removal of impacted tooth - completely bony	$75

D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$75
D7250	Removal of residual tooth roots (cutting procedure)	$75
D7260	Oroantral fistula closure	$75
D7261	Primary closure of a sinus perforation	$75
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$75
D7280	Exposure of an unerupted tooth	$75
D7283	Placement of device to facilitate eruption of impacted tooth	$75
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$75
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)	$75
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$75
D7471	Removal of lateral exostosis (maxilla or mandible)	$75
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	$75
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another	$75
D7970	Excision of hyperplastic tissue - per arch	$75
D7971	Excision of pericoronal gingiva	$75

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$20
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital or ambulatory surgical center call	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9910	Application of desensitizing medicament	$0
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9951	Occlusal adjustment - limited	$0
D9970	Enamel microabrasion	$0

For Services From a Non-Participating Provider Without a Referral

Out of Area Dental Emergency Treatment
The Company will reimburse the Enrollee up to $250 per visit for the cost of Covered Services. The Enrollee is responsible for all other charges and fees charged by the Non-Participating Provider, to the extent such amount exceeds $250.

All Other Treatment
The first $10 per visit of Covered Services will be covered. The Enrollee is responsible for all other charges and fees charged by the Non-Participating Provider, to the extent such amount exceeds $10.

Orthodontic Treatment

1. General Provisions.

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

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

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

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

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

f. The General Office Visit Copayment listed in the Schedule of Covered Services and Cost-Sharing is charged at each visit for orthodontic treatment. Services provided in connection with orthodontic treatment are subject to the Service Copayments listed in the Schedule of Covered Services and Cost-Sharing.

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: $1,800
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

Dental Implants

1. Benefits.

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

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

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

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

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

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

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

a. Any dental implant services and related services that are not listed as covered on this Dental Implant Section.
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 Enrollee's effective date of coverage under the Contract 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 the Contract.
i. Treatment of a primary or transitional dentition.

Exclusions and Limitations

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.

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.

2. The completion or delivery of treatments or services initiated prior to the effective date of coverage under the Contract, including the following:
   a. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Contract; or
   b. 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 insurance plan, and/or provider.

3. Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage. Such services are the liability of the Enrollee, prior dental plan, and/or provider.

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

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

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

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.

8. General anesthesia, moderate sedation, and deep sedation.

9. Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.

10. Maxillofacial prosthetic services.

11. Nightguards.

12. Orthognathic surgery.

13. Personalized restorations.

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

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

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

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

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

19. Replacement of sound restorations.

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

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

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

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

24. Services for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.

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

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

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

28. Services not included in the Schedule of Covered Services and Cost-Sharing, Orthodontic Treatment section, or Dental Implants section.

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

Limitations.

1. **Alternate Services.** If alternative services can be used to treat a condition, the service recommended by a Participating Provider is covered. In the event the Enrollee elects a service that is more costly than the service a 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.

2. **Congenital Anomalies.** Services listed in Schedule of Covered Services and Cost-Sharing which are provided to correct congenital anomalies are 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. "Congenital anomaly" means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term "significant deviation" is defined as a deviation that impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, and other conditions that are medically diagnosed to be congenital anomalies.

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

4. **Hospital Setting.** The Covered 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 Covered Services are authorized in writing by a Participating Provider;
   c. The Covered Services provided are the same Covered Services that would be provided in a dental office; and
   d. The applicable Copayments are paid.

5. **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.

6. **Restorations.** Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by a 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.

Section 1 Definitions

1.1 **"Child"** means a child of the Member (or Member's spouse), including a natural child; stepchild; adopted child; adopted child placed with the adoptive Member (or Member's spouse); or child by virtue of court-appointed legal guardianship. Child also includes a child for whom the Member (or Member's spouse) is required to provide dental coverage by a legal qualified medical child support order (QMCSO). "Placed" means physical placement in the care of the adopting Member (or Member's spouse)**.** In those circumstances when physical placement of a Child is prevented due to the medical needs of the Child, "placed" means the date the adopting Member (or Member's spouse) signs an agreement for adoption of the Child and assumes financial responsibility for the Child.

1.2 **"Company"** means Willamette Dental of Idaho, Inc.

1.3 **"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.

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

1.5 **"Covered Service"** means a dental service listed as covered in the Contract for which benefits are provided to Enrollees. Services not listed as a Covered Service in the Schedule of Covered Services and Cost-Sharing, the Orthodontic Treatment section, or the Dental Implants section are not covered.

1.6 **"Dental Emergency"** means a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate attention, including the following conditions: acute infection; acute abscesses; severe tooth pain; unusual swelling of the face or gums; or a tooth that has been avulsed (knocked out).

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

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

1.9 **"Dependent"** means a Member's legal spouse or Child, who is eligible and enrolled for coverage.

1.10 **"Enrollee"** means a Member or a Dependent.

1.11 **"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:

a. Whether the services are in general use in the dental community in the state of Idaho;
b. Whether the services are under continued scientific testing and research;

c. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
d. Whether the services are proven safe and effective.

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

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

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

1.15 **"Participating Provider"** means Willamette Dental Group, P.C., and the Dentists and Denturists employed by Willamette Dental Group, P.C. The Participating Provider is under contract with the Company to provide Covered Services to Enrollees. The Participating Provider agrees to charge Enrollees only the Copayments specified in the Contract for Covered Services.

1.16 **"Policyholder"** means Canyon County, the legal entity including approved affiliates and subsidiaries that the Contract is issued to.

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

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

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

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

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

Section 2 Eligibility and Enrollment

2.1 Eligible Employees. Employees must work a minimum of 40 hours per week to be eligible for coverage. Employees become eligible for coverage on the first day of the month following or coinciding with 1 month of continuous employment.

2.2 Eligible Family Members. Proof of eligibility may be required periodically. Any person who is covered under the Contract as a Member is not eligible for coverage as a Dependent.

2.2.1 Legal Spouse. The legal spouse of the Member is eligible for coverage as a Dependent.

2.2.2 Children. A Child is eligible for coverage as a Dependent to age 26.

2.2.3 Disabled Children. An unmarried Child is eligible for coverage as a Dependent beyond the limiting age if all of the following conditions are met:

a. The Child is and continues to be incapable of self-sustaining employment because of an intellectual disability or physical disability and who became so incapable prior to attainment of the limiting age.
b. The Child is and continues to be chiefly dependent upon the Member (or Member's spouse) for support and maintenance.
c. Proof of the Child's incapacity is provided within 31 days after the Child's attainment of the limiting age. Proof may be requested annually.

2.3 Initial Enrollment Period. The eligible employee must submit an enrollment application to the Policyholder for himself/herself and any eligible family members to be covered no later than 31 days after attaining initial eligibility. Coverage begins on 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 open enrollment period by submitting an enrollment application to the Policyholder. Coverage will begin on the anniversary date of the Contract.

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

2.5.1 Birth or Adoption. Eligible employees and their eligible family members may enroll following the birth or placement for adoption of an eligible Child by submitting an enrollment application to the Policyholder. An eligible newborn Child and eligible newly adopted Child are covered for 60 days following the date of birth or date of placement for adoption. Members may request to extend coverage beyond 60 days by submitting an enrollment application and paying of required Premium. The enrollment application must be provided within 60 days from the date of birth for newborn Children or 60 days from the earlier of the date of adoption or placement for adoption for newly adopted Children. The due date for payment of any additional Premium is 31 days after the date the monthly billing is received by the Policyholder and a notice of Premium is provided to the Member by the Policyholder. Coverage is effective as follows: (i) on the date of birth for newborn Children; (ii) on the date of birth for newborn adopted Children placed within 60 days of the adopted Child's date of birth; or (iii) the date of placement for newly adopted Children placed after 60 days from the adopted Child's date of birth. Coverage of enrolled newborn Children and enrolled newly adopted Children includes benefits for the Covered Services provided for medically necessary care and treatment of congenital anomalies.

2.5.2 Newly Acquired Family Members. Eligible employees and their newly acquired family members may enroll following marriage; court appointed legal guardianship of a Child; or issuance of a QMCSO by submitting an enrollment application and the applicable Premium to the Policyholder no later than 31 days after the event. Eligible employees or eligible family members may enroll if they become newly eligible for premium assistance under Children's Health Insurance Program (CHIP) or Medicaid by submitting an enrollment application and the applicable Premium to the Policyholder no later than 60 days after the determination for eligibility of premium assistance. Coverage will begin on the first day of the month after receipt of the enrollment application.

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

Section 3 Premium Provisions

3.1 Premium and Contract Revisions. Payment of the Premium after notice from the Company to the Policyholder of the revision constitutes the Policyholder's acceptance of the revision. The Company may revise the Premium rates and provisions of the Contract as follows:

3.1.1 At any time with 120 days prior written notice, based on any change in the characteristics of the Policyholder.

3.1.2 On the anniversary date of the Contract with 120 days prior written notice. If for any reason the annual renewal of the Contract is delayed beyond the anniversary date, the Company retains the right to revise the Premium and provisions of the Contract, effective on the first day of the month following 30 days prior written notice.

3.1.3 At any time if a change beyond the Company's control occurs, including but not limited to, a legislative or regulatory change. If a change in the Premium rates is necessary to offset the Company's costs, the Company will provide prior notice as soon as the cost impact can be determined.

3.1.4 The Company reserves the right to revise provisions of the Contract at any time upon 30 days written notice.

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

3.3 Return of Payment of Premium. The Company will refund to the Policyholder unearned collected Premium paid by the Policyholder for coverage after termination of the Contract or an Enrollee's termination date. Prior written notice of the intent to terminate in accordance with the Contract must be provided. The Policyholder must promptly notify all Enrollees of the termination of the Contract. If an Enrollee receives Covered Services after termination or during any period for which Premium is unpaid, the Participating Provider is entitled to recover the Reasonable Cash Value of the Covered Services provided.

Section 4 Dental Benefits

4.1 Services Provided by Participating Providers. The Company agrees to provide benefits for prescribed Covered Services provided by Participating Providers if the Covered Service satisfies all of the following conditions:

a. The dental services are listed as a Covered Service in the Schedule of Covered Services and Cost-Sharing, Orthodontic Treatment section, or Dental Implants section;
b. The dental services are dentally necessary;
c. The dental services are not otherwise excluded or limited as described in the Contract; and
d. The dental services are provided to an Enrollee, who is eligible and enrolled on the date the Covered Service is provided.

All Covered Services are expressly subject to the Copayments, limitations, and exclusions of the Contract.

Participating Providers will provide Enrollees with treatment of a Dental Emergency during office hours. The Company will provide benefits for Covered Services provided for treatment of a Dental Emergency provided by Participating Providers. If the Participating Provider's offices are closed, Enrollees 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.

4.2 Services Provided by Non-Participating Providers with a Referral. The Participating Provider may refer an Enrollee to a Non-Participating Provider for Covered Services. Covered Services provided by a Non-Participating Provider will be covered if:

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

When a Participating Provider refers an Enrollee to a Non-Participating Provider, the Copayments for Covered Services authorized by the referral will be the same amount as if a Participating Provider provided the services.

4.3 Non-Emergency Services Provided by Non-Participating Providers Without Referral. If an Enrollee elects to receive non-emergency services from a Non-Participating Provider without a referral, the first $10 per visit for Covered Services will be covered, subject to the exclusions described in the Contract. Charges for services in excess of $10 are not covered under the Contract. The Enrollee is financially responsible for all charges and fees charged by the Non-Participating Provider in excess of $10. A written request for reimbursement must be submitted to the Company within 6 months after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement.

4.4 Dental Emergency Services Provided by Non-Participating Providers. The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is 50-miles or more from the nearest Participating Provider's office. The Enrollee will be reimbursed in accordance with the out of area emergency dental care reimbursement amount shown in the Schedule of Covered Services and Cost-Sharing for Covered Services provided for treatment of the Dental Emergency, minus applicable Copayments. The Enrollee is financially responsible for any charges for Covered Services provided for treatment of a Dental Emergency in excess of the out of area emergency dental care reimbursement benefit and any services not covered under the Contract. The Enrollee must submit to the Company a written request for reimbursement within 6 months after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information may be requested, including X-rays, to process the request. The reimbursement benefit for out of area Dental Emergency treatment is contingent upon receipt of complete information.

4.5 Copayments. The Enrollee is responsible for payment of the General Office Visit Copayment or the Specialist Office Visit Copayment at each visit. Some Covered Services require a Service Copayment. Service Copayments are in addition to the Office Visit Copayments. Service Copayments may be due at the time of service.

4.6 Member Coverage. A Member may not be simultaneously covered more than once as a Member under the Contract.

4.7 Coordination of Benefits. This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay for Covered Services. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expenses.

4.7.1 Definitions.

a. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

Each contract for coverage under 1 or 2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

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

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

   The following are examples of expenses that are not Allowable Expenses:

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

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
f. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

4.7.2 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 Idaho's COB regulation 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 that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
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. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
   (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
         - The Plan covering the Custodial Parent;
         - The Plan covering the legal spouse of the Custodial Parent;
         - The Plan covering the non-Custodial Parent; and then
         - The Plan covering the legal spouse of the non-Custodial Parent.
   (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of subsection (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled e.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 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 shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

4.7.3 Effect on the Benefits of This Plan.

a. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any request for benefits to be paid or provided, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the request for benefits do not exceed the total Allowable Expense for that request for benefits. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
b. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

4.7.4 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 Company and 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 Company and 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 Company and Participating Provider any facts it needs to apply those rules and determine benefits payable.

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

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

Section 5 Termination Provisions

5.1 Termination of Coverage. An Enrollee's coverage shall terminate on the earliest of the events described below.

5.1.1 On the date the Contract terminates.

5.1.2 On the last day of the month for which Premium is paid, if the Premium is not paid through the Policyholder on behalf of the Enrollee within the grace period.

5.1.3 On the last day of the month during which eligibility ceases, unless the Enrollee is eligible for and elects continuation coverage.

5.1.4 On the last day of the month in which the Enrollee exhausts continuation rights, if any.

5.1.5 On the last day of the month following 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 a Participating Provider, office staff, or other patients, or nonpayment of Copayments.

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

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

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

5.4 Continuation Rights. Continuation coverage may be available to certain Enrollees for a limited time, as described below. The Policyholder agrees to administer continuation coverage in accordance with applicable laws and notify all Enrollees of their rights to continuation coverage. For more information regarding continuation rights, Enrollees should contact the Policyholder.

5.4.1 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. The Policyholder is responsible for administering continuation coverage pursuant to federally mandated or state-mandated leave acts or laws.

5.4.2 COBRA. In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, certain circumstances, called qualifying events, generally requires employers with 20 or more employees in the prior year to offer Members and some Dependents the right to continue coverage beyond the time it would ordinarily end. Federal law governs COBRA continuation rights and obligations. If applicable, the Policyholder is responsible for administering COBRA continuation coverage and informing Enrollees of their COBRA continuation rights.

5.4.3 Labor Disputes. If a Member'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 Member pays the Premium to the Policyholder as it becomes due, including the Policyholder's portion, if any. The Policyholder shall notify the Member in writing of the right to continue coverage. The Premium rates during a work stoppage are equal to the Premium rates 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 after the Member begins full-time employment with another employer; or
d. The date of termination of the Contract.

5.4.4 Leave of Absence. If permitted by the Policyholder, coverage may continue for up to 3 months during a Policyholder-approved temporary leave of absence that is not covered under Section 5.4.1.

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

5.5 Reinstatement. The probationary period is waived for employees who are rehired no later than 90 days after employment terminates. The probationary period is waived for Members who become ineligible for coverage due to a reduction of work hours, if the employee becomes eligible again no later than 90 days after the date coverage terminated. Coverage will begin on the first day of the month following or coinciding with the date of re-hire or re-eligibility for coverage.

5.6 Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Enrollees whose coverage is terminated by the Company for good cause or failure to pay the Premium are not eligible for an extension of benefits.

5.6.1 Crowns or Bridges. Adjustments of crowns or bridges are covered for six months following the placement of the crown or bridge if the final impressions are taken prior to the coverage termination date and the crown or bridge is placed no later than 60 days after termination.

5.6.2 Removable Prosthetic Devices. Adjustments of removable prosthetic devices are covered for six months following the placement of the removable prosthetic device if final impressions are taken prior to the coverage termination date and the removable prosthetic device is placed within 60 days of the coverage termination date. Laboratory relines are not covered after the coverage termination date.

5.6.3 Immediate Dentures. The delivery of immediate dentures is covered if final impressions are taken prior to the coverage termination date and the dentures are delivered within 60 days of the coverage termination date. If coverage terminates prior to the extraction of teeth, the extractions are not covered.

5.6.4 Root Canal Therapy. The completion of root canal therapy will be covered if the root canal is started prior to the coverage termination date and treatment is completed within 60 days of the coverage termination date. Pulpal debridement is not a root canal start. If the root canal requires retreatment 60 days or more after the coverage termination date, retreatment will not be covered. Restorative work following root canal treatment is a separate procedure and is not covered after the coverage termination date.

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

6.1 Subrogation. Covered Services for the diagnosis or treatment of an injury or disease, which was 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.

6.1.1 If the Company and Participating Provider provide Covered Services for the treatment of an injury or disease possibly caused by a third party, they shall:

a. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the 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 services provided, subject to the limitations specified below.

6.1.2 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 relevant 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 reasonable action to seek and obtain recovery to reimburse the Company and Participating Provider for the Reasonable Cash Value of the services provided.

6.1.3 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.

6.1.4 The Contract does not provide benefits for 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.

6.2 Complaints, Grievances, and Appeals.

6.2.1 Complaints.

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

b. If the Enrollee requests a specific service, a 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 Idaho, 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 a Participating Provider, Participating Provider's staff, or Member Services Department, grievance and appeal procedures are available.

6.2.2 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.

6.2.3 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.

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.

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

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

6.4 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 Dentists; or similar causes; the Company 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.

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

6.6 Liability. The Policyholder and Enrollees shall not be held liable, assessable, or in any way subject to payment for the debts, liabilities, insolvency, impairment, or any other financial obligations of the Company.

6.7 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 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.

6.8 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.

6.9 Statements. In the absence of fraud, all statements made by applicants or the Policyholder or by an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Policyholder or the insured person.

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.

Willamette Dental
Corporate Privacy Statement

At Willamette Dental Management Corporation and its affiliated companies, Willamette Dental Group, P.C., Willamette Dental Insurance, Inc., Willamette Dental of Washington, Inc., and Willamette Dental of Idaho, Inc., ("Willamette Dental", collectively) we value the trust subscribers and patients ("customer or customers", collectively) have placed in us. That is why we welcome this opportunity to describe the steps we take to protect customer information. This Statement provides details about these policies and procedures.

- We do not sell customer information.
- We do not share customer information with outside persons or companies for unrelated purposes such as selling their products or services.
- We do not share customer health information provided as part of a dental record, insurance application or claim, with outside persons or companies, except for legally authorized purposes.
- We maintain security standards and procedures designed to protect customer information.
- We require outside persons or companies that validly need our customer information to protect the confidentiality and prohibit independent use of customer information.
- We afford prospective and former customers the same protections as existing customers with respect to the use of customer information.

INFORMATION COLLECTION

The primary reason that we collect and maintain customer information is to serve and administer customer relationships. This information may be collected from a variety of sources, such as the following:

- Information provided to us on applications or forms, such as names, addresses, dates of birth, and phone, social security, insurance and account numbers; and
- Information resulting from dental treatment, and dental account transactions, obtained from within Willamette Dental and from non-affiliated companies we work with to administer our business, including such information as health history, dental records, payment history and credit history.

HEALTH INFORMATION CONFIDENTIALITY

We will not disclose health information to anyone without authorization unless the law permits or requires us to do so. Our contractual relationships with health care providers, as well as state and federal laws require the providers to keep customer health information confidential. Willamette Dental, its health care providers and payers (including self-funded employers) require access to customers' medical/dental information for a number of necessary reasons. These reasons include underwriting, claims payment, fraud prevention, case management, delivery of care, quality assessment, utilization review, compliance with state and federal requirements, data collection and reporting, accreditation, and statistical research. Customer authorization as well as federal and state laws permits these disclosures.

INFORMATION USE AND DISCLOSURE WITHIN WILLAMETTE DENTAL

We use and share customer information within Willamette Dental to provide products, services and administer our business. The information we maintain about customer relationships helps us verify identity, provide insurance benefits and dental treatment, and administer claims. Within Willamette Dental, we share the customer information we collect with our affiliates as reasonably necessary, including to provide dental care, dental insurance, enrollment, eligibility, claims management, billing and accounting.

WITH OUTSIDE COMPANIES OR PARTIES

We share information outside Willamette Dental only for necessary and appropriate business purposes. We require these non-affiliates to keep customer information confidential. We may disclose customer information to the following types of outside companies or parties:

- Insurers, insurance administrators, benefit administrators, dentists and health care providers;
- Companies that perform services on our behalf, such as check printing, preparation of account statements, and product marketing;
- Government, credit, and collection agencies and other outside entities as permitted or required by federal and state law. These disclosures are made for specific limited purposes, such as to verify identity, credit and accounts, collect debts or respond to a court order or subpoena; and
- Others, such as technical consultants engaged to program our computer systems to help us provide, track, analyze and market our services and products.

INFORMATION CONFIDENTIALITY AND PROTECTION PRACTICES

Willamette Dental is committed to preventing others from unauthorized access to customer information, and we maintain procedures and technology designed for this purpose. We take steps to protect the customer information we have, including the following:

- We update our technology in accordance with federal and state privacy regulations to improve the protection of customer information; and
- We have internal procedures that limit access to customer information, such as procedures requiring an employee to have a business need to access customer information. We maintain policies to provide security of workplaces and records.

INFORMATION INTEGRITY MEASURES

At Willamette Dental, we work hard to ensure customer information is complete and accurate. We have procedures and processes for updating our customer information. We protect the integrity and survivability of customer information through measures such as maintaining backup copies of account data in the event of power outages or other business interruptions, using computer virus detection and eradication software on systems containing customer information, upgrading computer hardware and software, and employing other technical means to protect against unauthorized computer entry into systems containing customer information.

COMMUNICATION

To contact Willamette Dental, write to: Willamette Dental Privacy Officer
Willamette Dental Management Corporation
6950 NE Campus Way
Hillsboro, Oregon 97124

Non-discrimination Statement

Willamette Dental Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Willamette Dental Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Willamette Dental Group:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-855-433-6825.

If you believe that Willamette Dental Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Member Services Department,
6950 NE Campus Way
Hillsboro, Oregon 97124
1-855-433-6825
Fax 503-952-2684
memberservices@willamettedental.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-433-6825.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-433-6825。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-433-6825.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-433-6825.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-433-6825 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-433-6825.

Українська (Ukrainian)
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-433-6825.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-433-6825 まで、お電話にてご連絡ください。

Mon-Khmer, Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-433-6825 ។

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-433-6825.

Oroomiffa (Oromo) (Cushite)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-433-6825.

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-433-6825.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-433-6825 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-433-6825 .

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-433-6825 .

Willamette Dental Group