GROUP DENTAL CERTIFICATE OF COVERAGE

Policyholder Name: Pioneer Educators Health Trust

Effective Date: April 1, 2010

Contract Number: Z908-A

This Certificate of Coverage ("Certificate"), including any amendments, appendices, endorsements, notices and riders, summarizes the essential features of the Contract.

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

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

WILLAMETTE DENTAL INSURANCE, INC.
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Article 1 Definitions

The following defined terms are used throughout the Contract.

"Benefit" means the covered service or supply an Enrollee is entitled to receive.

"Company" means Willamette Dental Insurance, Inc.

"Contract" means the agreement between the Company and the Policyholder.

"Co-payment" means the dollar amount that Enrollees must pay for receiving Benefits.

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

"Dentist" means a doctor of dental surgery or a doctor of medical dentistry, licensed in the state where treatment is rendered.

"Dependent" means an eligible spouse, domestic partner, or child, who is enrolled for coverage.

"Enrollee" means any Member or Dependent.

"Member" means an eligible employee of a Participating Employer Group, who is enrolled for coverage.

"Participating Dentist" means a Dentist employed by the Participating Provider.

"Participating Employer Group" means any employer which is a member of the Policyholder and whose participation under this Contract has been approved in writing by the Policyholder and the Company.

"Participating Provider" means Willamette Dental Group, P.C., or any of its affiliated dental practices. The Company engages the Participating Provider to provide dental services.

"Plan Administrator" means the Policyholder or the entity designated by the Policyholder as its fiduciary. These duties include, but are not limited to, issuance of monthly eligibility reports, payment of Premium, and the issuance and receipt of any notices under this Contract.

"Policyholder" means Pioneer Educators Health Trust.

"Premium" means the payment, including any Member contributions, which the Policyholder must pay to the Company for coverage.

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

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

Section 2.1 **Member Eligibility**. An active employee, who regularly works at least the minimum number of hours required by the Group's eligibility policy document, becomes eligible for coverage on the first day of the calendar month following or coinciding with completion of the waiting period as required by the Group's benefit eligibility document.

Section 2.2 **Dependent Eligibility**. The Plan Administrator or Company may require proof of dependency periodically.

2.2.1 The spouse of the Member or the domestic partner of the Member is eligible for coverage as a Dependent. All provisions of the Contract applicable to a spouse will be applicable to a domestic partner. For the purpose of the Contract, the use of the terms "spouse" and "marriage" will be applicable to a domestic partner and domestic partnership, to the extent that such interpretation does not conflict with federal law.

2.2.2 The Member's, spouse's, or domestic partner's child from birth through age 25 is eligible for coverage as a Dependent. Child includes: a natural child; stepchild; adopted child; child for whom the Member, spouse, or domestic partner has assumed a legal obligation for support of the child in anticipation of adoption of the child; or child for whom the Member, spouse, or domestic partner is a court appointed guardian.

a. An unmarried child reaching the limiting age may continue coverage as a Dependent if the following conditions are met.
   1. The child is and continues to be incapable of self-sustaining employment because of a developmental disability or physical handicap.
   2. The child is and continues to be chiefly dependent upon the Member or spouse for support and maintenance.
   3. The Plan Administrator provides proof satisfactory to the Company within 31 days after the child becomes ineligible. The Company may request proof annually.

b. A child is eligible if required by a Qualified Medical Child Support Order as defined in the Employee Retirement Income Security Act of 1974, as amended.

Section 2.3 **Enrollment and Commencement of Coverage.**

2.3.1 **Member.**

a. The Company must receive the enrollment application within 31 days after the Member attains eligibility, or the prospective Member must wait until the Contract's next open enrollment period to enroll.

b. If the prospective Member becomes eligible for Children's Health Insurance Program (CHIP) premium assistance or Medicaid, the Member must submit an enrollment application and additional premium within 60 days of the date eligibility is determined.

c. Coverage begins on the date the Member satisfies applicable eligibility and enrollment requirements.

2.3.2 Dependents.

a. Dependents must be listed on the Member's enrollment application or Dependents must wait until the Contract's next open enrollment period to enroll.

b. If a Dependent is not eligible when the Member enrolls, and later becomes eligible, the Member should submit an enrollment application and the applicable Premium within 31 days after the Dependent becomes eligible or the Dependent must wait until the Contract's next open enrollment period to enroll.

c. A Dependent newly eligible due to marriage may enroll. The Member must submit enrollment application and the applicable Premium within 60 days following the date of marriage.

d. Coverage begins on the first day of the next calendar month after the Dependent satisfies applicable eligibility and enrollment requirements. A Dependent's coverage will not be effective prior to the effective date of the Member's coverage.

e. If the Dependent becomes eligible for CHIP assistance or Medicaid, the Member must submit an enrollment application and additional Premium within 60 days of the date eligibility is determined.

f. A Member may request coverage for an eligible newborn child by submitting an enrollment application. If additional Premium is due to provide coverage for such child, the additional Premium must be paid within 60 days after such child's birth. Coverage will begin on the date of birth.

g. A Member may request coverage for an eligible adopted child by submitting an enrollment application. If additional Premium is due to provide coverage for such child, the additional Premium must be paid within 60 days of the date of placement for adoption or following assumption of a legal obligation for the child's support. Coverage will begin on the date of placement for adoption or the date of assumption of a legal obligation for the child's support in anticipation of adoption of the child.

h. If a Member drops a Dependent from coverage, he or she cannot re-enroll until the Contract's next open enrollment period.

2.3.3 Enrollment Due to Loss of Coverage. A prospective Enrollee may enroll following a documented involuntary loss of coverage under another employer health plan. Involuntary includes termination of Dependent's employment, divorce or legal separation, death of spouse, or spouse's leave of absence. The Company must receive the enrollment application and Premiums within 63 days of loss of coverage. If coverage is lost under a CHIP assistance or Medicaid, the Company must receive the enrollment application and applicable Premium within 60 days of the loss of coverage.

Article 3 Premium Provisions

Section 3.1 **Payment of the Premium.** The payment of Premium for each Enrollee is due on the first day of each month ("Due Date"). The Plan Administrator must submit payment Premium for all Enrollees to the Company in a single lump sum. A 30-day grace period is granted for the payment of Premium. The Company may provide written notice if payment of Premiums is past due. If Premiums remain unpaid at the end of the grace period, the Company shall be released from all further obligations under the Contract. No person is entitled to Benefits for any period during which Premium is unpaid.

Section 3.2 **Premiums if Coverage is Continued.** If the Enrollee is eligible for continuation rights and elects to continue coverage, the Enrollee must submit timely payment of Premiums through the Plan Administrator.

Section 3.3 **Return of Advance Premium Payment**. If the Policyholder submits early payment of Premiums prior to the termination of the Contract, the Company will return the unearned Premium to the Plan Administrator. Prior written notice of the intent to terminate in accordance with the Contract must be provided. The Plan Administrator must promptly notify all Enrollees of the termination of the Contact. If an Enrollee receives Benefits after termination or for any period for which Premium remains unpaid, the Company is entitled to recover the Reasonable Cash Value of the Benefits provided in the form of services for that period.

Section 4.1 **Agreement to Provide Benefits.** The Company agrees to provide Benefits for prescribed services listed in the appendices. Services must be provided by a Participating Provider to receive Benefits, unless specified otherwise. The Participating Provider agrees it will accept the amounts established by the Company and the Co-payments specified in appendices as full payment for the covered services provided. All Benefits are expressly subject to the Co-payments stated in the appendices and to all other provisions of the Contract.

Section 4.2 **Referral to a Specialist.** If a Participating Dentist cannot provide a covered service, the Participating Dentist may refer an Enrollee to a Specialist or non-participating Dentist. The Company agrees to provide Benefits for services and supplies provided by a Specialist or non-participating Dentist only if:

a. The Participating Dentist refers the Enrollee;
b. The services and supplies are authorized by the referral; and
c. The services and supplies are listed as covered in the appendices.

Section 4.3 **Office Visit Co-payment.** The Enrollee is responsible for payment of an office visit Co-payment for each visit to a Participating Dentist, Specialist, or authorized referral Dentist. Office visit Co-payments are payable at each visit.

Section 4.4 **Service or Supply Co-payment.** Some services or supplies may require a service Co-payment. Service Co-payments are payable at the time of service.

Section 4.5 **Member Coverage.** A Member may not be simultaneously covered more than once as a Member under the Contract.

Section 4.6 **Rights Not Transferable.** Benefits are offered personally to the Enrollee and are not transferable.

Section 5.1 **Exclusions.** The Company does not provide Benefits for any of the following conditions, treatments, services, supplies, or for any direct complications or consequences thereof. The Company does not provide Benefits for an excluded service or supply even if approved, prescribed, or recommended by a Dentist.

5.1.1 Services or supplies that are not listed as covered in Appendix A.

5.1.2 Exams or consultations needed solely in connection with a service or supply not listed as covered in Appendix A.

5.1.3 Services or supplies by any person other than a Dentist, licensed denturist, hygienist, or dental assistant within the scope of his or her license.

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

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

5.1.6 Experimental or investigational services or supplies and related exams or consultations.

a. In determining whether services or supplies are experimental or investigational, the Company will consider the following:
   1. Whether the services or supplies are in general use in the dental community in the State of Oregon;
   2. Whether the services or supplies are under continued scientific testing and research;
   3. Whether the services or supplies show a demonstrable benefit for a particular illness, disease, or condition; and
   4. Whether the services or supplies are proven safe and efficacious.

5.1.7 Services or supplies and related exams or consultations that are not within of the prescribed treatment plan and/or are not recommended and approved by the Participating Dentist attending the Enrollee.

5.1.8 General anesthesia or moderate sedation.

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

5.1.10 Services or supplies for treatment of intentionally self-inflicted injuries.

5.1.11 Services or supplies for treatment of injuries sustained while practicing for or competing in a paid athletic contest of any kind.

5.1.12 Services or supplies 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.

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

5.1.14 Services or supplies for which coverage is available under any other employer-sponsored health plan.

5.1.15 The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage under this 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 this Contract; or

b. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under this Contract.

5.1.16 Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.

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

5.1.18 Dental implants, including attachment devices and their maintenance.

5.1.19 Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.

5.1.20 Nightguards.

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

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

5.1.23 Personalized restorations.

5.1.24 Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

5.1.25 Endodontic services, prosthetic services, and implants that are defective, were not provided in accordance with the professional standard of care, or were provided prior to the effective date of coverage. Such services or supplies are the liability of the Enrollee, prior dental insurance carrier, and/or Dentist.

5.1.26 Replacement of sound restorations.

5.1.27 Orthognathic surgery.

5.1.28 Services or supplies provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons. Please also refer to the limitation under Section 5.2.4

5.1.29 Services or supplies for the diagnosis or treatment of temporomandibular joint disorders.

5.1.30 Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice are not a Benefit.

Section 5.2 Limitations.

5.2.1 Replacements. The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture 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 this Contract, and replacement by a permanent denture is necessary.

5.2.2 Alternate Services. If alternative services can be used to treat a condition, the service recommended by the Participating Dentist is covered. In the event the Enrollee elects a service that is more costly than the service the Participating Dentist has approved, the Enrollee is responsible for the Co-payment for the recommended covered service plus the cost differential between Reasonable Cash Value of the recommended service and Reasonable Cash Value of the more costly requested service.

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

a. A hospital or similar setting is medically necessary.
b. The services are pre-authorized in writing by a Participating Dentist.
c. The services provided are the same services that would be provided in a dental office.
d. The Hospital Call Co-payment and applicable Co-payments as specified in Appendix A are paid.

5.2.4 Congenital Malformations. Services or supplies listed in Appendix A which are provided to correct congenital or developmental malformations of the teeth and supporting structure will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.

5.2.5 Crown, cast, or other indirect fabricated restorations are covered only if dentally necessary or if recommended by the Participating Dentist. Dentally necessary means it is treatment for decay, traumatic injury or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.

5.2.6 Endodontic Retreatment.

a. When initial root canal therapy was performed by a Participating Dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable Co-payment will apply as identified in Appendix A.

b. When the initial root canal therapy was performed by a non-participating Dentist, the retreatment of such root canal therapy by a Participating Dentist will be subject to the applicable Co-payment identified in Appendix A.

Section 6.1 **Termination of Coverage.** Coverage shall terminate on the earliest of the following:

6.1.1 On the date of termination of the Contract.

6.1.2 At the end of the last month for which Premium is paid, if the Premium is not received by the Due Date or within the grace period as specified in Article 3.

6.1.3 At the end of the month during which eligibility ceases.

6.1.4 At the end of the month, following at least 30 days advance written notice 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 Dentist, physical or verbal abuse towards a Participating Dentist, office staff, or other patients, or non-payment of Co-payments.

6.1.5 At the end of the month during which the armed forces of the United States of America calls the Member to active duty.

6.1.6 If coverage terminates for a Member, it will terminate for Dependents.

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

Section 6.3 **Cessation of Benefits.** No person shall have or acquire a vested right to receive Benefits after termination of the Contract. Termination of the Contract completely ends all obligations of the Company to provide Benefits, even if the Enrollee was receiving treatment while the Contract was in force or needs treatment for any existing condition, unless specified otherwise.

Section 6.4 **Continuation Rights.** The Plan Administrator may postpone the termination of coverage for any Enrollee as described below. The Plan Administrator agrees to notify all Enrollees of their right to continuation of coverage and administer continuation of coverage in accordance with state and federal laws.

6.4.1 **Leave of Absence.** For 3 months during a temporary, employer approved leave of absence. The leave of absence is considered to have begun when the Member is no longer receiving a full salary, but no later than 90 calendar days from the date the Member is no longer actively at work.

6.4.2 **Spouse Continuation Coverage.** A legally separated, divorced, or surviving spouse age 55 or over may elect to continue coverage, in accordance with Oregon law. Eligible children of the spouse may remain covered. For complete information regarding rights under the Spouse Continuation Coverage, please contact the Plan Administrator.

6.4.3 State-Mandated Continuation Coverage. Coverage may continue in accordance with any state-mandated leave act or law, including Oregon Administrative Rule 836-053-0865 which extends the period of continuation coverage to no less than 9 months. For complete information regarding rights under the state-mandated continuation of coverage, please contact the Plan Administrator.

6.4.4 COBRA. If the plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, certain circumstances, called qualifying events, give Members and some Dependents the right to continue coverage beyond the time it ordinarily would end. Federal law governs COBRA continuation rights and obligations. The Plan Administrator is responsible for administering COBRA continuation coverage. For complete information regarding rights under the COBRA, please contact the Plan Administrator.

6.4.5 During a Labor Dispute. If a Member ceases to satisfy the minimum working requirement due to a strike, lockout, or other general work stoppage caused by a labor dispute, coverage may continue for up to 6 months.

a. The following rules will apply:
   1. If a Member's compensation is suspended or terminated because of a work stoppage caused by a labor dispute, the Plan Administrator will notify the Member in writing of the right to continue coverage.
   2. The Member must pay Premium through the Plan Administrator, including the Policyholder or Participating Employer Group's portion.
   3. Premium rate during a work stoppage is equal to the Premium rate. The Company may change Premium rates according to the provisions of the Contract.

b. Coverage will terminate on the earlier of:
   1. On the last day of the month following any Premium Due Date, if Premium is unpaid.
   2. On the last day of the 6th month, following the date the work stoppage began.
   3. On the last day of the month after the Member begins full-time employment with another employer.
   4. On the date of termination of the Contract.

6.4.6 6-Month Extension. Coverage may continue for a period of up to 6 months for any Enrollee who is no longer eligible for coverage, except for termination of employment due to misconduct. This provision shall run concurrently with COBRA if the Enrollee is eligible for COBRA.

Section 6.5 Reinstatement.

6.5.1 If coverage terminates because a Member ceases to meet the eligibility requirements set forth in Article 2 and becomes eligible again within 90 days, the Member may re-enroll. The Member must re-enroll within 31 days from the date of re-eligibility or wait until the Contract's next open enrollment period. Coverage will begin on the first day of the calendar month following or

coinciding with the date of re-eligibility for coverage, if the Member satisfies the applicable eligibility and enrollment requirements.

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

Section 6.6 **Extension of Benefits**. Benefits for the following services that require multiple appointments may extend after coverage ends. Anyone terminated for good cause or failure to make timely payment is not eligible for an extension of Benefits.

6.6.1 **Crowns or Bridges.** Adjustments for crowns or bridges will be covered for up to 6 months after placement if the final impressions are taken prior to termination and the crown or bridge is placed within 60 days of termination.

6.6.2 **Removable Prosthetic Devices.** Adjustments for removable prosthetic devices will be covered for up to 6 months after placement if final impressions are taken prior to termination and the prosthesis is delivered within 60 days after termination. Laboratory relines are not covered after termination.

6.6.3 **Immediate Dentures.** Benefits for dentures may be extended if final impressions are taken prior to termination and the dentures are delivered within 60 days after termination. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.

6.6.4 **Root Canal Therapy.** Benefits for root canal therapy will be extended if the root canal is started prior to termination and treatment is completed within 60 days after termination. Pulpal debridement is not a root canal start. If after 60 days from termination of coverage the root canal requires re-treatment, re-treatment will not be covered. Restorative work following root canal treatment is a separate procedure and not covered after termination.

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

Section 7.1 Emergency Care.

7.1.1 The Emergency Office Visit Charge Co-payment, specified in Appendix A, is charged at each visit to seek treatment for a Dental Emergency. If Participating Provider's offices are closed, Enrollee may access after-hours clinical assistance by calling the Appointment Center at (800) 359-6019.

7.1.2 The Enrollee may seek treatment from any Dentist for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Participating Provider office. The Enrollee may seek reimbursement for the cost of the covered services rendered up to the Out of Area Emergency Reimbursement amount less any Co-payment amounts specified in Appendix A. A written request for reimbursement must be submitted to the Company within 6 months of the date of service. The written request should include the Enrollee's signature, the attending Dentist's signature, and the attending Dentist's itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The Out of Area Emergency Reimbursement will not be provided if the requested information is not received.

Section 7.2 Coordination of Benefits. This Coordination of Benefits (COB) provision applies when a person has dental care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a request for reimbursement for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

7.2.1 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 insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: individual benefits, hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate Plan. If a

Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

b. This plan means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental care benefits 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.

7.2.2 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 of under any other Plan.

b. 1. Except as provided in Paragraph 2., a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

d. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or

retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

   b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

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

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

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

      The Plan covering the Custodial parent;

      The Plan covering the spouse of the Custodial parent;

      The Plan covering the non-custodial parent; and then

      The Plan covering the spouse of the non-custodial parent.

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

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan

covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

7.2.3 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 reimbursement, the Secondary plan will calculate the benefits it would have paid in the absence of other dental 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 reimbursement do not exceed the total Allowable expense for that request for reimbursement. 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.

7.2.4 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 Participating Provider may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This

plan and other Plans covering the person claiming benefits. The Participating Provider need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Participating Provider any facts it needs to apply those rules and determine benefits payable.

7.2.5 **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.

7.2.6 **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 7.3 **Subrogation.** Benefits may be available for an injury or disease, which is allegedly the liability of a third party. Such services provided by Participating Provider are solely to assist the Enrollee. By incurring the Reasonable Cash Value of the Benefits provided in the form of services, the Participating Provider is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

7.3.1. If the Participating Provider provides services for the treatment of an injury or disease, which is allegedly the liability of a third party, it shall:

a. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Benefits provided in the form of services; and

b. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Benefits provided in the form of services, subject to the limitations specified in below.

7.3.2 As a condition of receiving Benefits, the Enrollee shall:

a. Provide the Participating Provider with the name and address of the parties liable, all facts known concerning the injury, and other information as reasonably requested;

b. Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Participating Provider's subrogation rights; and

c. Take all necessary action to seek and obtain recovery to reimburse the Participating Provider.

7.3.3 The Participating Provider shall be reimbursed with any amounts received from the third party or third party's insurer(s). The amount shall not exceed the Reasonable Cash Value of the services or supplies provided for treatment of the injury or disease.

7.3.4 The Contract does not provide Benefits for services or supplies 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.

7.3.5 The refusal or failure, without good cause, to cooperate with the Company or Participating Provider are grounds for recovery by the Participating Provider from the Enrollee for the Reasonable Cash Value of the Benefits provided in the form of services.

Section 7.4 Complaints, Grievances, and Appeals Procedures.

7.4.1 Complaints.

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

b. If the Enrollee requests a specific service, the Participating Dentist will use his or her judgment to determine if the service is dentally necessary. The Participating Dentist will recommend the most appropriate course of treatment.

c. Enrollees may also contact the Company's Member Relations Department with questions or complaints.

Willamette Dental Insurance, Inc., Attn: Member Relations
6950 NE Campus Way, Hillsboro, OR 97124-5611
(800) 460-7644

d. If the Enrollee remains unsatisfied after discussing with the Participating Dentist or the Member Relations Department, grievance and appeal procedures are available for complaints pertaining to a denied Benefit or service.

7.4.2 Grievances.

a. A grievance is a written complaint expressing dissatisfaction with the denial of a requested Benefit or service. 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 Relations Department within 180 days after the denial of Benefits or services.

b. The Company will review the grievance and all information submitted. The Company will provide a written reply within 30 days of 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 Benefit request involves:

1. A preauthorization, the Company will provide a written reply within 15 days.
2. Services deemed experimental or investigational, the Company will provide a written reply within 20 working days.
3. Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 72 hours.

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

7.4.3 Appeals.

a. An appeal is the process for requesting reconsideration of a denied grievance. Appeal request must be submitted, in writing, to the Member Relations Department within 180 days of the date on the written reply to the grievance. 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 within 60 days of the receipt. If the appeal involves:

1. A preauthorization, the Company will provide a written reply within 30 days.
2. Services deemed experimental or investigational, the Company will provide a written reply within 20 working days.
3. Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 72 hours.

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.

Section 7.5 **Modification of Contract.** No modification of the Contract is binding upon the Company unless it is in writing and signed by an officer of the Company.

Section 7.6 **Force Majeure.** If due to circumstances not within the Company's reasonable control, including but not limited to, major disaster, labor dispute, complete or partial destruction of facilities, disability of a material number of the Participating Dentists, or similar causes, the provision of Benefits available under the Contract is delayed or rendered impractical, the Company and its affiliates shall not have any liability or obligation on account of such delay or failure to provide Benefits, except to refund the amount of the unearned advanced Premiums 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.

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

Section 7.8 **Severability.** If any provision of the Certificate is deemed invalid or illegal, that provision shall be fully severable and the remaining provisions of the Contract shall continue in full force and effect.

Section 7.9 **Clerical Error.** Clerical error shall not invalidate coverage or extend coverage. Upon discovery of an error, the Premiums, Co-payments, and/or fees shall be adjusted. The Company may revise any contractual document issued in error.

Section 7.10 **Statements.** All statements made by applicants, the Policyholder, Participating Employer Group, or an insured person are representations which the Company may rely upon. Statements made for acquiring insurance shall not void the insurance or reduce Benefits, unless contained in a written instrument signed by the Policyholder, Participating Employer Group or the insured person.

Schedule of Covered Services and Co-payments

Code	Procedure	Co-payment
1.	**General Office Visit Charge**	$10
	Specialist Office Visit Charge	$30
	Emergency Office Visit Charge	$10
2.	**Diagnostic and Preventive Services**	
D0120	Periodic oral evaluation	None
D0140	Limited oral evaluation-emergency	None
D0145	Oral evaluation for patient under three	None
D0150	Comprehensive oral evaluation	None
D0160	Detailed & extensive oral evaluation	None
D0170	Re-evaluation - limited	None
D0180	Comprehensive periodontal exam	None
D0210	Complete series x-rays	None
D0220	Periapical-first film	None
D0230	Intraoral - each additional film	None
D0240	Intraoral - occlusal film	None
D0250	Extraoral - first film	None
D0260	Extraoral - each additional	None
D0270	Bitewings - single film	None
D0272	Bitewings - two films	None
D0273	Bitewings - three films	None
D0274	Bitewings - four films	None
D0277	Vertical Bitewings	None
D0330	Panoramic x-rays	None
D1110	Teeth cleaning (prophylaxis) adult	None
D1120	Teeth cleaning (prophylaxis) child	None
D1203	Topical fluoride-child	None
D1204	Topical fluoride-adult	None
D1206	Topical fluoride-varnish	None
D1310	Nutritional Counseling	None
D1320	Tobacco counseling	None
D1330	Oral Hygiene Instruction	None
D0340	Cephalometric film	None
D0350	Oral / facial images	None
D1351	Sealant/tooth	None
D0425	Caries Susceptibility Tests	None
D0460	Pulp vitality test	None
D0470	Diagnostic casts	None
3. Space Maintainers		
D1510	Space Maintainer – unilateral-fixed	None
D1515	Space Maintainer – bilateral-fixed	None
D1520	Space Maintainer – unilateral-removable	None
D1525	Space Maintainer – bilateral-removable	None

D1550	Space Maintainer – recement	None
D1555	Removal of fixed space maintainer	None

4. Restorative Dentistry

a. Amalgam Restorations

D2140	Fillings – 1 surface	None
D2150	Fillings – 2 surfaces	None
D2160	Fillings – 3 surfaces	None
D2161	Fillings – 4 or more surfaces	None
D2951	Pin retention – per tooth, in addition to restoration	None
D2940	Sedative filling – temporary	None

b. Resin Restorations

D2330	Resin-1 surface (anterior only)	None
D2331	Resin-2 surfaces (anterior only)	None
D2332	Resin-3 surfaces (anterior only)	None
D2335	Resin-4 surfaces (anterior only)	None
D2950	Core buildup, including any pins	None
D2390	Resin Based composite crown	None
D2391	Resin-one surface posterior primary	None
D2391	Resin-one surface posterior permanent	None
D2392	Resin-two surfaces posterior primary	None
D2392	Resin-two surfaces posterior permanent	$52
D2393	Resin-three surfaces posterior primary	None
D2393	Resin-three surfaces posterior permanent	$52
D2394	Resin-four or more surfaces posterior primary	None
D2394	Resin-four or more surfaces posterior permanent	$52

c. Inlay/Onlay (cast restorations)

D2510	Inlay-gold 1 surface	$50
D2520	Inlay-gold 2 surfaces	$50
D2530	Inlay-gold 3 or more surfaces	$50
D2542	Onlay-gold 2 surfaces	$50
D2543	Onlay-gold 3 surfaces	$50
D2544	Onlay-gold 4 or more surfaces	$50
D2610	Inlay-porcelain/ceramic 1 surface	$50
D2620	Inlay-porcelain/ceramic 2 surfaces	$50
D2630	Inlay-porcelain/ceramic 3 surfaces	$50
D2642	Onlay-porcelain/ceramic 2 surfaces	$50
D2643	Onlay-porcelain/ceramic 3 surfaces	$50
D2644	Onlay-porcelain 4 or more surfaces	$50
D2910	Recement inlay	None

5. Crowns

D2710	Crown-resin laboratory	$50
D2740	Crown-porcelain/ceramic (anterior only)	$50
D2750	Crown-porcelain – noble	$50
D2780	¾ crown – noble	$50
D2792	Full cast crown – noble	$50
D2920	Recement crown	None
D2930	Stainless Steel crown-primary	None
D2931	Stainless Steel crown-permanent	None
D2932	Crown-prefabricated resin	None

D2933	Crown-prefabricated stainless steel w/resin window	None
D2954	Prefabricated dowel post & core	None
D2955	Post removal (no endo therapy)	None
D2957	Each additional prefabricated post - same tooth	None
D2970	Temporary crown for fractured tooth	None
D2980	Repair crown	None

6. Endodontics

D3110	Pulp cap-direct excluding final restoration	None
D3120	Pulp cap-indirect	None
D3220	Pulpotomy – A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	None
D3221	Gross pulpal debridement – primary & permanent teeth	None
D3230	Pulpal therapy – primary anterior	None
D3240	Pulpal therapy – primary posterior	None
D3310	Root canal therapy – anterior	$30
D3320	Root canal therapy – bicuspid	$60
D3330	Root canal therapy – molar	$90
D3331	Treatment of root canal obstruction – non-surgical access	None
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	None
D3333	Internal repair of perforation defects	None
D3346	Retreatment – anterior	$30
D3347	Retreatment – bicuspid	$60
D3348	Retreatment – molar	$90
D3351	Apexification – initial visit	$90
D3352	Apexification – interim visit	None
D3353	Apexification – final visit	None
D3410	Apicoectomy – anterior	$30
D3421	Apicoectomy – bicuspid 1st root	$60
D3425	Apicoectomy – molar 1st root	$90
D3426	Apicoectomy – each additional root	None
D3430	Retrograde filling – per root	None
D3450	Root amputation per tooth	$90
D3920	Hemisection	$90
D3950	Canal prep-preform dowel/post	None

7. Periodontics

D4210	Gingivectomy or gingivoplasty – four or more teeth	$50
D4211	Gingivectomy – one to three teeth	$30
D4240	Gingival flap – four or more teeth	$50
D4241	Gingival flap – one to three teeth	$50
D4249	Crown lengthening hard tissue	$50
D4260	Osseous surgery – four or more teeth	$50
D4261	Osseous surgery – one to three teeth	$50
D4263	Bone replacement graft – 1st site in quadrant	None
D4264	Bone graft – each additional site in quadrant	None
D4270	Pedicle soft tissue graft procedure	$50
D4271	Free soft tissue graft procedure	$50
D4273	Subepithelial connective graft	$50
D4274	Distal wedge procedure	$50
D4341	Periodontic scale & root plane – four or more teeth	$30

D4342	Periodontic scale & root plane – one to three teeth	$30
D4355	Preliminary full-mouth debridement	None
D4381	Antimicrobial irrigation	None
D4910	Periodontic maintenance following therapy	None

8. Prosthodontics - Removable

D5110	Complete (upper denture)	$100
D5120	Complete (lower denture)	$100
D5130	Immediate (upper denture)	$100
D5140	Immediate (lower denture)	$100
D5211	Upper partial (resin base)	$100
D5212	Lower partial (resin base)	$100
D5213	Upper partial (cast metal frame)	$100
D5214	Lower partial (cast metal frame)	$100
D5281	Partial-removable unilateral	$100
D5410	Adjustment – complete denture, upper	None
D5411	Adjustment – complete denture, lower	None
D5421	Adjustment – partial denture, upper	None
D5422	Adjustment – partial denture, lower	None
D5510	Repair broken denture no teeth damaged	None
D5520	Repair denture replace missing or broken teeth (each tooth)	None
D5610	Repair resin base	None
D5620	Repair partial cast framework	None
D5630	Repair or replace partial clasp	None
D5640	Replace teeth – partial per tooth	None
D5650	Add tooth to existing partial	None
D5660	Add clasp to existing partial	None
D5710	Rebase complete upper denture	None
D5711	Rebase complete lower denture	None
D5720	Rebase upper partial	None
D5721	Rebase lower partial	None
D5730	Reline complete upper denture (chairside)	None
D5731	Reline complete lower denture (chairside)	None
D5740	Reline upper partial (chairside)	None
D5741	Reline lower partial (chairside)	None
D5750	Reline upper denture - lab	None
D5751	Reline lower denture – lab	None
D5760	Reline upper partial – lab	None
D5761	Reline lower partial – lab	None
D5810	Interim denture – upper	$50
D5811	Interim denture – lower	$50
D5820	Interim partial – upper	$50
D5821	Interim partial – lower	$50
D5850	Tissue conditioning – upper	None
D5851	Tissue conditioning – lower	None
D5860	Overdenture – complete	$100
D5861	Overdenture – partial	$100
D5986	Fluoride gel custom trays	None

9. Prosthodontics - Fixed

D6210	Pontic, cast (per tooth) traditional fixed partial dentures only (bridges)	$50

D6240	Pontic (per tooth); porcelain/metal traditional fixed partial dentures only (bridges)	$50
D6241	Pontic (per tooth) maryland bridge	$50
D6545	Cast metal retainer	$50
D6720	Crown-resin/metal abutment	$50
D6750	Crown-porcelain metal abutment	$50
D6780	Crown ¾ cast metal abutment	$50
D6790	Crown – full gold abutment	$50
D6930	Recement bridge	None
D6972	Prefabricated post/core in addition to bridge	None
D6973	Core build-up w/wo pins	None
D6975	Coping – metal	None
D6980	Bridge repair	None

10. Oral Surgery

D7111	Extraction – coronal remnants primary tooth	None
D7140	Extraction – erupted tooth	None
D7210	Surgical extraction – erupted	$50
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partial bony	$50
D7240	Removal of impacted tooth – complete bony	$50
D7241	Removal of impacted tooth – complete bony with complications	$50
D7250	Surgical removal residual root	$50
D7260	Oroantral fistula closure	$50
D7270	Tooth re-implantation	$50
D7280	Surgical access – unerupted tooth	$50
D7283	Ortho bracket to aid eruption (if plan has Orthodontia coverage)	$50
D7291	Transseptal fiberotomy	$50
D7310	Alveoloplasty w/extractions-per quadrant	None
D7320	Alveoloplasty w/o extractions-per quadrant	None
D7340	Vestibuloplasty	$50
D7350	Vestibuloplasty – more complex	$50
D7471	Removal of exostosis – per site	$50
D7510	I & D intraoral soft tissue	None
D7520	I & D extraoral soft tissue	None
D7530	Remove foreign body – soft tissue	None
D7540	Remove foreign body – hard tissue	None
D7550	Partial ostectomy/sequestrectomy for removal of non vital bone	None
D7670	Stabilization splint-alveolus	None
D7910	Suture small wound up to 5 cm	None
D7911	Complicated suture up to 5 cm	None
D7953	Bone replacement graft for ridge preservation – per site	$50
D7960	Frenectomy	$50
D7970	Excision hyperplastic tissue	$50
D7971	Excision of pericoronal flap	$50

11. Anesthesia

D9220	General Anesthesia – 1st 30 minutes	Not covered
D9221	General Anesthesia – Each additional 15 minutes	Not covered
D9230	Nitrous Oxide (per visit)	$10

12. Miscellaneous

D9110	Palliative (emergency) minor	None
D9310	Consultation – per session	None
D9420	Hospital call (Dental treatment provided in a hospital setting) - Service co-payments still apply and facility fees not covered.	$125
D9430	Observation visit	None
D9440	Emergency treatment – after office hours	$20
D9951	Occlusal adjustment - simple	None
D9911	Application of desensitizing medicaments	None
D9952	Occlusal adjustment - complete	None
	Out of Area Emergency Reimbursement	$100

Orthodontic Treatment

1. General Provisions.

a. Benefits for orthodontic treatment are provided only if the Participating Dentist prepares the treatment plan prior to rendering services. 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 Co-payments.

c. For orthodontic treatment started prior to the effective date of coverage, Co-payments may be adjusted based upon the services necessary to complete the treatment.

d. If Benefits for orthodontic services terminate prior to completion of orthodontic treatment, Benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the co-payment may be pro-rated. The services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

e. The Enrollee is responsible for payment of the Co-payments listed below for pre-orthodontic and orthodontic services rendered. The Pre-Orthodontic Service Co-payments will be deducted from the Comprehensive Orthodontic Service Co-payment if the Enrollee accepts the treatment plan.

f. Services connected with orthodontic treatment are subject to the Co-payments listed in Appendix A.

2. Pre-Orthodontic Service Co-payment.

a.	Initial orthodontic exam:	$ 25
b.	Study models and x-rays:	$ 125
c.	Case presentation:	$ 0

3. Orthodontic Service Co-payment.

a.	Comprehensive Orthodontic Service Co-payment:	$ 1,200

WILLAMETTE DENTAL GROUP
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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/14/2003, 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 health information that we maintain, including 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 HEALTH INFORMATION

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

Treatment: We may use and disclose your health information to a dentist, hygienist or other healthcare provider for treatment purposes.

Payment: We may use and disclose your health information to bill for and collect payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare providers, evaluating provider performance, conducting training programs, peer review, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose 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 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 when you bring your spouse with you when treatment is discussed. We may use our professional judgment to infer that it is in your best interest to allow another person to pick-up filled prescriptions, medical supplies, x-rays or recommend that they take you to your physician or emergency room.

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as postcards, voicemail message, or letters) or information about oral health care, and related benefits and services.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your 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 practicable provide, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your 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 health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 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 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 payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 health information or in response to a request you made to amend or restrict the use or disclosure of your 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 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.

Patient 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