GROUP DENTAL PLAN

OEBB

Delta Dental Premier Plan 2

Effective Date: October 1, 2011

www.odscompanies.com/oebb

Member handbooks and more are available at www.odscompanies.com/oebb

Insurance products provided by Oregon Dental Service

TABLE OF CONTENTS

SECTION 1. WELCOME

Oregon Dental Service (ODS) was created in 1955 and was the first company in America to provide prepaid dental coverage.

ODS is pleased to have been chosen by the participating organization as its dental plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed below or access tools and resources on ODS' personalized member website, myODS, at www.odscompanies.com/oebb. myODS is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

During the first appointment, members should tell the dentist they have dental benefits through ODS. Members will need to provide the subscriber identification number and ODS Group number to the dentist. These numbers are located on the I.D. card.

ODS
601 S.W. Second Avenue
Portland, Oregon 97204

ODS Dental Customer Service Department

Portland	503-265-2910
Toll Free	866-923-0410
Relay Services	711
	(for the hearing and speech impaired)
En Español	503-265-2963
Llamado Gratis	877-299-9063

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its members for legitimate business purposes as determined by ODS. The monitoring is to ensure the quality and accuracy of the service provided by employees of ODS to all members.

Note: This handbook may be changed or replaced at any time, by OEBB or ODS, without the consent of any member. All plan provisions are governed by OEBB's policy with ODS. This handbook may not contain every plan provision.

SECTION 2. GENERAL PLAN INFORMATION

2.1 Plan Name:
OEBB

2.2 Plan Sponsor:
Oregon Educators Benefit Board

2.3 Type of Plan: Group Dental Benefit Plan**.**

2.4 Plan Year: October 1st through September 30th**.**

2.5 Plan Administrator: The Plan Sponsor is the administrator of the Plan.

2.6 Funding Medium and Type of Plan Administration: The Plan is fully insured. Benefits are provided under a group insurance policy entered into between Oregon Educators Benefit Board and ODS. Claims for benefits are sent to ODS. ODS, not Oregon Educators Benefit Board, is responsible for paying claims.

The Plan is funded by the participating organization and/or subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion a subscriber pays toward the total contribution is determined by the participating organization.

2.7 Provider of Benefits: Benefits are provided in accordance with a policy of insurance between ODS and Oregon Educators Benefit Board.

2.8 Named Fiduciary: Oregon Educators Benefit Board.

SECTION 3. USING THE PLAN

ODS' dental plans are easy to use and cost effective. If members choose a participating Premier dentist from the ODS Premier Dental Directory (which is available on ODS' website at www.odscompanies.com/oebb under "Find Care"), all of the paperwork takes place between ODS and the dentist's office. More than 90% of all licensed dentists in Oregon are ODS participating Premier dentists. For travelers and employees outside Oregon, ODS' national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Members needing dental care may go to any dental office. However, **there are differences in reimbursement by ODS for participating Premier dentists and non-participating dentists.** An example is provided in section 16.2. While a member may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

At an initial appointment, members should tell the dentist that they have dental benefits through ODS. Members will need to provide their subscriber identification number and ODS Group number to the dentist. These numbers are located on the I.D. card.

For expensive treatment plans, ODS provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current contract and returned to the dentist. The member and his or her dentist should review the information before beginning treatment.

For questions about the Plan, members should contact ODS' Dental Customer Service Department.

This handbook describes the benefits of the Plan. It is the responsibility of the members to review this handbook carefully and to be aware of the Plan's limitations and exclusions.

3.1 MEMBER RESOURCES

ODS Website (log in to **myODS**)
www.odscompanies.com/oebb

Dental Customer Service Department
Portland 503-265-2910; Toll-free 866-923-0410; En Español 503-265-2963; Llamado gratis 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

SECTION 4. DEFINITIONS

The following are definitions of some important terms used in this handbook. Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Member Benefits Guide and the OEBB Administrative Rules.

Accepted Fee means the filed fee approved by ODS for a specific dental procedure performed by a participating Premier dentist submitting that fee and performing that dental service. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to ODS' Dental Consultant who determines a comparable code to the one billed. ODS will use the maximum plan allowance for the comparable code to price the claim.

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

Amalgam is a silver-colored material used in restoring teeth.

Anterior refers to teeth located at the front of the mouth. (tooth chart in section 16.1)

Benefit Year means a plan year or portion thereof. See also: Claim Determination Period.

Benefits means those dental services that are available under the terms of the Plan.

Bicuspid is a premolar tooth, between the front and back teeth. (tooth chart in section 16.1)

Bridge is also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Retainer crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

Cast Restoration includes crowns, inlays, onlays, and any other restoration to fit a specific member's tooth that is made at a laboratory and cemented into the tooth.

Claim Determination Period means the plan year or portion thereof commencing October 1 of any calendar year and ending September 30 of the subsequent calendar year.

Coinsurance means the percentages of covered expenses to be paid by a member.

Composite is a tooth-colored material used in restoring teeth.

Debridement is the removal of excess plaque. A periodontal 'pre-cleaning' procedure done when there is too much plaque for the dentist to perform an exam.

Deductible is the amount of covered expenses that are paid by a member before benefits are payable by the Plan.

Dentally Necessary means:

a. Services that are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan;

b. Services that are appropriate with regard to standards of good dental practice in the service area;
c. Services that have a good prognosis; and/or
d. Services that are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

Note:
The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Dentist means a duly licensed dentist, legally entitled to practice dentistry at the time and in the place services are performed; to the extent that he or she is operating within the scope of his or her license as required under law within the state of practice.

Denture Repair is a procedure done to fix a complete, immediate, or partial denture. This includes adding a tooth to a partial denture, replacing a broken tooth in a denture, or fixing broken framework and/or base.

Enrolled Dependent means a subscriber's eligible spouse, domestic partner, or child whose application has been accepted by OEBB and who is enrolled in the Plan.

The **Group** is the organization whose employees are covered by the Plan.

Group Health Plan means any plan, fund or program established and maintained by the participating organization for the purpose of providing healthcare for its employees or their dependents through insurance, reimbursement or otherwise. This dental benefit plan is a group health plan.

Implant is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed bridge, or partial or full denture.

Implant Abutment is an attachment used to connect an implant and an implant supported prosthetic device.

Implant Supported Prosthetic is a crown, bridge, or removable partial or full denture that is supported by or attached to an implant.

Maximum Payment Limit means the amount payable by the Plan for covered services received each plan year, or portion thereof, for each member.

Maximum Plan Allowance (MPA) is the maximum amount that ODS will reimburse providers. For a participating Premier dentist, the maximum amount is the dentist's filed or contracted fee with ODS/Delta Dental. For non-participating dentists, the maximum amount is based on a per service average allowance of the participating Premier dentists' filed fees. *The non-participating dentist has the right to bill the difference between ODS' maximum plan allowance and the actual charge. This difference will be the member's responsibility.*

Member means a subscriber, spouse, domestic partner or child of a subscriber or an individual otherwise eligible for the Plan who has enrolled for coverage under the terms of the Plan.

Mental Incapacity, for the purposes of this handbook, means intellectual competence usually characterized by an IQ of less than 70.

Non-participating Dentist means a licensed dentist who has not agreed to the terms and conditions established by ODS that participating Premier dentists have agreed to.

ODS means Oregon Dental Service, a not-for-profit dental healthcare service contractor.

Participating Premier Dentist means a licensed dentist who has agreed to render services in accordance with terms and conditions established by ODS and has satisfied ODS that he or she is in compliance with such terms and conditions.

Periodic Exam is a routine exam (check-up), commonly performed every 6 months.

Periodontal Maintenance is a periodontal procedure for members who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

Physical Incapacity, for the purposes of this handbook, means the inability to pursue an occupation or education because of a physical impairment.

The **Plan** is the dental benefit plan sponsored by OEBB and insured under the terms of the policy between OEBB and ODS.

The **Policy** is the agreement between OEBB and ODS for insuring the dental benefit plan sponsored by OEBB. This handbook is a part of the policy.

Pontic is an artificial tooth that replaces a missing tooth and is part of a bridge.

Posterior refers to teeth located toward the back of the mouth. (tooth chart in section 16.1)

Prophylaxis is cleaning and polishing of all teeth.

Reline means the process of resurfacing the tissue side of a denture with new base material.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

Retainer is a tooth used to support a prosthetic device (bridges, partial dentures or overdentures). Also see "**Implant Abutment."**

Subscriber means any eligible employee or former employee who is enrolled in the Plan.

Veneer (chairside and laboratory) is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast) at a laboratory. Chairside and laboratory veneers may be paid at different benefit levels.

ViziLite Plus TBlue is a non-excisional soft tissue screening to detect oral cellular abnormalities.

SECTION 5. BENEFITS AND LIMITATIONS

Below is a general list of services the Plan covers when performed by a dentist,, denturist or registered hygienist. These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A dentist shall determine these standards. In no case will benefits be paid for services provided beyond the scope of a practitioner's license, certificate or registration.

Covered dental services are outlined in 4 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, and are noted below. See Section 8 for exclusions.

Deductible: $50.00
Per member per plan year, or portion thereof
Deductible applies to covered Class II, Class III, and Class IV services

Maximum payment limit: $1,500.00
Per member per plan year, or portion thereof.
All covered services (Class I, II, III, IV) apply to maximum payment limit.

Late enrollees have a 12-month waiting period for Class II, Class III, and Class IV services, but are eligible for Class I services (details for Late Enrollees, see section 10.5)

5.1 PREVENTIVE CARE

5.1.1 Class I: 70% is provided toward covered Class I services in the first plan year a member is covered.

Payment increases by 10% each successive plan year. To qualify for this 10% increase, the member must visit the dentist at least once during the plan year. Failure to do so will cause a 10% reduction in payment for the next plan year, although payment never drops below 70%.

Class I services will be covered at 100% at the end of 3 plan years, assuming at least one visit to the dentist each of these years.

5.1.2 Diagnostic

a. **Diagnostic Services:**
   i. Examination
   ii. Intra-oral x-rays to assist in determining required dental treatment.

b. **Diagnostic Limitations:**
   i. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period*.
   ii. Complete series x-rays or a panoramic film is covered once in any 3-year period*.

iii. Supplementary bitewing x-rays are covered once in any 6-month period*.
iv. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
v. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
vi. ViziLite Plus TBlue is covered once in any 6-month period*.

5.1.3 Preventive

a. **Preventive Services:**
   i. Prophylaxis (cleanings)
   ii. Periodontal maintenance
   iii. Topical application of fluoride
   iv. Space maintainers
   v. Sealants

b. **Preventive Limitations:**
   i. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*†.
   ii. Topical application of fluoride is covered once in any 6- month period* for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period* if there is a history of periodontal disease or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
   iii. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
   iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

*These time periods are calculated from the previous date of service.
†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see section 6).

5.2 RESTORATIVE SERVICES

5.2.1 Class II: 70% is provided toward covered Class II services the first plan year a member is covered.

Payment increases by 10% each successive plan year. To qualify for this 10% increase, the member must visit the dentist at least once during the plan year. Failure to do so will cause a 10% reduction in payment for the next plan year, although payment never drops below 70%.

Class II services will be covered at 100% at the end of 3 plan years, assuming at least one visit to the dentist each of these years.

5.2.2 Restorative

a. **Restorative Services:**
   i. Provides amalgam fillings on posterior teeth and composite fillings on anterior teeth for the treatment of carious lesions (decay).

b. **Restorative Limitations:**
   i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
   ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
   iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 5.3.2.
   iv. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.
   v. Composite, resin, or similar (tooth colored) restorations in posterior teeth are considered optional services. Coverage shall be made for a corresponding amalgam restoration. **If a composite filling is used to restore posterior teeth, benefits are limited to the amount paid for an amalgam filling. The member is responsible for paying the difference.**

5.2.3 Oral Surgery

a. **Oral Surgery Services:**
   i. Extractions (including surgical),
   ii. Other minor surgical procedures,
   iii. General anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

b. **Oral Surgery Limitations:**
   i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
   ii. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
   iii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
   iv. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

5.2.4 Endodontic

a. **Endodontic Services:**
   i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

b. **Endodontic Limitations:**
   i. A separate charge for cultures is not covered.
   ii. Pulp capping is covered only when there is exposure of the pulp.
   iii. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

5.2.5 Periodontic

a. **Periodontic Services:**
   i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

b. **Periodontic Limitations:**
   i. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
   ii. Coverage for periodontal maintenance procedure under Class I, Preventive.
   iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
   iv. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

5.3 MAJOR DENTAL CARE

5.3.1 Class III: 70% is provided toward covered Class III services the first plan year a member is covered.

Payment increases by 10% each successive plan year. To qualify for this 10% increase, the member must visit the dentist at least once during the plan year. Failure to do so will cause a 10% reduction in payment for the next plan year, although payment never drops below 70%.

Class III services will be covered at **100%** at the end of 3 plan years, assuming at least one visit to the dentist each of these years.

5.3.2 Restorative

a. **Restorative Services:**
   i. Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

b. **Restorative Limitations:**
   i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 5.2.1.1 for limitations on buildups.
   ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
   iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

5.4 PROSTHODONTIC SERVICES

5.4.1 Class IV: 70% is provided toward covered Class IV services the first plan year a member is covered.

Payment increases by 10% each successive plan year. To qualify for this 10% increase, the member must visit the dentist at least once during the plan year. Failure to do so will cause a 10% reduction in payment for the next plan year, although payment never drops below 70%.

Class IV services will be covered at **100%** at the end of 3 plan years, assuming at least one visit to the dentist each of these years.

5.4.2 5.4.1 Prosthodontic

a. **Prosthodontic Services:**
   i. Bridges,
   ii. Partial and complete dentures,
   iii. Denture relines,
   iv. Repair of an existing prosthetic device
   v. Implants

b. **Prosthodontic Limitations:**
   i. A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
   ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
   iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
   iv. Denture adjustments, repairs, and relines*:* A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
   v. Tissue conditioning is covered no more than twice per denture in a 36-month period.
   vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The Plan will also benefit:
      A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
      B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or

C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period.
D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.

viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

5.5 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the dentist's fee.

5.6 NON-PARTICIPATING DENTISTS

The amounts payable for services of a non-participating dentist are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating dentist fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance.

SECTION 6. ORAL HEALTH, TOTAL HEALTH PROGRAM

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy.

Recent studies have indicated a relationship between periodontal disease, bacteria in the mouth, and various health problems. These problems can include pre-term, low birth weight babies and diabetes. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

6.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

ODS cares about its members' overall health and has developed a program for ODS members based on this new evidence. To be eligible for the additional benefits described in this section, enrollment in the Oral Health, Total Health program is required.

6.1.1 Diabetes

If members have diabetes, elevated blood sugar levels can have a negative effect on their oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control.

Diabetic members covered under the Plan are eligible for a total of 4 prophylaxes (cleanings) or periodontal maintenance sessions per plan year. However, this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this handbook.

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member must complete and return the Oral Health, Total Health enrollment form along with proof of diabetes diagnosis. The enrollment form can be accessed by visiting myODS or by calling ODS' Dental Customer Service Department.

6.1.2 Pregnancy

Keeping the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. By enrolling in the Oral Health, Total Health program, members are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. However, this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this handbook.

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact ODS' Dental Customer Service Department or complete and return the Oral Health, Total Health enrollment form found on myODS.

SECTION 7. ORTHODONIC BENEFIT

This benefit may or may not apply to all members. Please check with your participating organization.

7.1 ORTHODONTIC BENEFIT

Orthodontic services are a benefit for members.

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

ODS will pay 80% toward covered orthodontic services, up to the orthodontic lifetime services maximum $1,800.00 per member. This lifetime maximum is not included in the dental plan annual maximum. The orthodontic services started prior to enrolling for coverage under this Plan will be pro-rated according to the extent of orthodontic services provided by the Group to complete the treatment plan.

There is a 12-month waiting period for orthodontic services for late enrollees.

If the Plan has a deductible, it does not apply to orthodontic services.

7.2 LIMITATIONS

ODS' obligation to make payments for treatment will cease upon termination of treatment for any reason prior to completion, or upon termination of eligibility or of the Plan.

If treatment began before the member was eligible under the Plan, ODS will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

Repair or replacement of an appliance furnished under the Plan is not covered.

SECTION 8. EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise dentally necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a dental provider.

Anesthesia or Sedation
The Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.

Anesthetics, Analgesics, Hypnosis, and Medications
Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs are excluded.

Benefits Not Stated
Exclusions include all other services or supplies not specifically included in this handbook as covered dental services under the Plan.

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service are not covered, except as stated in section 11.1.

Congenital or Developmental Malformations
Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.

Cosmetic
Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.

Experimental Procedures
Experimental procedures or supplies are excluded.

Facility Fees
Hospital or facility charges for services or supplies, or additional fees charged by the dentist for hospital, extended care facility or home care treatment are excluded.

Gnathologic Recordings
Gnathologic recordings or similar procedures are excluded.

Instructions or Training
Plaque control and oral hygiene or dietary instruction are not covered.

Localized Delivery of Antimicrobial Agents
Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.

Missed Appointments
Charges for missed or broken appointments are excluded.

Orthodontia
Orthodontic services (treatment of malalignment of teeth and/or jaws) are excluded. This exclusion may or may not apply to all members. Please check with your participating organization.

Periodontal Charting
A separate charge for periodontal charting is not covered.

Precision Attachments

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

Services on Tongue, Lip, or Cheek
Services performed on the tongue, lip or cheeks are not covered.

Services Otherwise Available
This exclusion includes:

a. Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
b. Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
c. Services which are provided, without cost to the member, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan; or
d. Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the member enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, is excluded.

Services Provided By a Relative
ODS will not reimburse services provided by members or their relatives. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Service, War or Insurrection, Riot or Rebellion
The Plan does not cover treatment of any condition caused by or arising out of service in the armed forces of any country or the active participation in a war or insurrection, or the voluntary participation in a riot or rebellion.

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party. This includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. (See section 11.3).

TMJ
Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.

Treatment After Coverage Terminates
The Plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III, and Class IV services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends. This provision is not applicable if the Group transfers its plan to another carrier.

Treatment Before Coverage Begins
Dental services started prior to the date the member became eligible for such services under the Plan are excluded.

Treatment Not Dentally Necessary
The Plan does not cover:

a. Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan;
b. Services that are inappropriate with regard to standards of good dental practice;
c. Services with poor prognosis.

SECTION 9. ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administration Rules under OAR 111-015-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on eligibility. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found in the "Enrollment" section (see Section 10).

9.1 ELIGIBILITY AUDIT

ODS reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee timecards, member birth certificates, adoption paperwork, marriage certificates, domestic partnership registration and any other document necessary to document eligibility on the Plan.

SECTION 10. ENROLLMENT

10.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010. Members may also refer to the OEBB Member Benefits Guide for additional information on enrollment.

10.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040. Members may also refer to the OEBB Member Benefits Guide for additional information on qualified status changes.

Eligible employees and their spouse, domestic partner, or children may also have additional enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009. If prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

In addition, if an eligible employee, spouse, domestic partner, or child covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.
The special enrollment rights as described above apply:

- To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy;
- To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy; or,
- To both the eligible employee and the dependent if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee will need to submit a complete and signed application within the required timeframe.

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children. If payment is required but not received, the child will not be covered. A signed copy of court ordered guardianship will be required for coverage of a grandchild.

10.3 EFFECTIVE DATES

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on the effective date of coverage.

The necessary premiums must also be paid for coverage to become effective.

10.4 OPEN ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020. Members may also refer to the OEBB Member Benefits Guide for additional information on open enrollment.

10.5 LATE ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020. Members may also refer to the OEBB Member Benefits Guide for additional information on open enrollment.

10.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those individuals returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0035. Members may also refer to the OEBB Member Benefits Guide for additional information on returning to active eligible employee status.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Any exclusion period that was not completed at the time the subscriber was laid off or had a reduction in hours must be satisfied. However, the period of layoff or reduction in hours will be counted toward the exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

10.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

The Plan's rules for removing an ineligible individual from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015. Members may also refer to the OEBB Member Benefits Guide for additional information on removing an ineligible individual from the Plan.

10.8 WHEN COVERAGE ENDS

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

10.8.1 Termination of the Group Plan

If the Plan is terminated for any reason, coverage ends for the participating organization and members on the date the Plan ends.

10.8.2 Termination by a Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving ODS written notice through OEBB, in accordance with OEBB's Administrative Rules. Coverage will end on the last day of the month through which premiums are paid. If a subscriber terminates his or her own coverage, coverage for any dependents also ends at the same time.

10.8.3 Rescission by Insurer

The Plan's enrollment rules for rescission by insurer are outlined in OEBB's Administrative Rules. Members may also refer to the OEBB Member Benefits Guide for additional information on rescinding.

10.8.4 Certificates of Creditable Coverage

Certificates of creditable coverage will be issued when coverage ends, when COBRA coverage ends, and when a member requests a certificate while covered under the Plan or within 2 years of losing coverage.

10.8.5 Other

Additional information is in Section 14.

10.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on declining coverage.

SECTION 11. CLAIMS ADMINISTRATION AND PAYMENT

The following section explains how claims are administered.

11.1 SUBMISSION AND PAYMENT OF CLAIMS

11.1.1 Claim Submission

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred at the address listed below. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

ODS
Attn: Dental
601 S.W. Second Avenue
Portland, Oregon 97207

11.1.2 Explanation of Benefits (EOB)

Soon after receiving a claim, ODS will report its action on the claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myODS. ODS may pay claims, deny them, or apply the allowable expense toward satisfying the deductible, if any. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 11.1.1.

11.1.3 Claim Inquiries

ODS' Dental Customer Service Department can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. ODS will respond to an inquiry within 30 days of receipt.

11.2 DISPUTE RESOLUTION

11.2.1 Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

An adverse determination is a written notice from the Plan, in the form of a letter or an Explanation of Benefits (EOB), which has set forth the following:

a. the specific reason or reasons for the benefit denial,
b. reference to the specific plan provision on which the denial was based,
c. a description of any additional material or information necessary for a member to complete the claim and an explanation of why such material or information is necessary, and
d. appropriate information as to the steps to be taken if the member wishes to appeal the determination, including the right to submit written comments and have them considered and the right to review (on request and at no charge) relevant documents and other information.

Utilization Review means a system of reviewing the necessity, appropriateness, or quality of services and supplies using specified guidelines, including the application of practice guidelines, prior authorization of procedures, and retrospective review. An adverse benefit determination that the item or service is not necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a professional judgment is a utilization review decision.

11.2.2 Time Limit For Submitting Claims

Members have **180 days** from the date of an adverse benefit determination to submit an initial written appeal regarding that determination. If an initial written appeal is not submitted within the timeframes outlined in this section, the member will lose the right to the appeal process.

11.2.3 The Review Process

The Plan has a 2-level review process. The first level of review is called a first level appeal. The second level of review is a second level appeal. ODS' response time to an appeal is based on the nature of the claim as described below.

Note:
The timelines addressed in the paragraphs below do not apply when:

a. The time period is too long to accommodate the clinical urgency of the situation;
b. The member does not reasonably cooperate; or
c. Circumstances beyond the control of either party prevents that party from complying with the standards set, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

11.2.4 First Level Appeal

Members may request that ODS review an adverse benefit determination. It may be possible to resolve the situation with a phone call to ODS' Dental Customer Service Department. Otherwise, a first level appeal must be submitted in writing. If necessary, ODS' Dental Customer Service Department can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. ODS' response time to the appeal is based on the nature of the claim. The appeal will be reviewed by persons not previously involved in the case. The investigation will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, ODS will send a written notice of the decision to the member, including the basis for the decision. If applicable, the notice will include information on the right to a second level appeal.

11.2.5 Second Level Appeal

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. A second level appeal must be made within 60 days of the date of ODS' action on the first level appeal. A second level appeal must be submitted in writing. The second level appeal will be reviewed by persons not previously involved in the review of the case. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will follow the same timelines outlined in section 11.2.4. ODS will notify the member in writing of the decision, including the basis for the decision.

11.3 BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which healthcare expenses may be the responsibility of someone other than ODS. Here are descriptions of the situations that may arise.

11.3.1 Coordination of Benefits (COB)

This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation of COB is in 0.

11.3.2 Third-Party Liability

A member may have a legal right to recover benefit or healthcare costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or healthcare costs were paid by ODS. For example, a member who is injured may be able to recover the benefits or healthcare costs from a person or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, a member may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the illness or injury. Should ODS make an advance payment of benefits, as described below, it is entitled to be reimbursed for any benefits it paid that are associated with any illness or injury that are or may be recoverable from a third party or other source. Amounts received by ODS through these recoveries help reduce the cost of premiums and providing benefits.

Because recovery from a third party may be difficult and take a long time, and payment of benefits where a third party may be legally liable is excluded under the terms of the Plan, as a service to the member, ODS will pay a member's expenses based on the understanding and agreement that the member is required to honor ODS' rights of subrogation as discussed below, and, if requested, to reimburse ODS in full from any recovery the member may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that ODS shall have the remedies and rights as stated in this section. ODS may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, ODS' right of reimbursement or subrogation as discussed in this section. ODS has the sole discretion to interpret and construe these reimbursement and subrogation provisions.

11.3.3 Definitions:

For purposes of section 11.3.2, the following definitions apply:

Benefits means any amount paid by ODS, or submitted to ODS for payment to or on behalf of a member. Bills, statements or invoices submitted to ODS by a provider of services, supplies or facilities to or on behalf of a member are considered requests for payment of benefits by the member.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a member, regardless of the characterization of the claims, or damages of the member, and regardless of the characterization of the recovery funds. (For example, a member who has received payment of dental/medical expenses from ODS may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, ODS is still entitled to recover benefits as described in section 11.3.2.)

Third Party means any person or entity responsible for the injury or illness, or the aggravation of an injury or illness, of a member. Third party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.

Recovery Funds means any amount recovered from a third party.

11.3.4 Subrogation

Upon payment by the Plan, ODS shall be subrogated to all of the member's rights of recoveries therefore, and the member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this section, ODS may pursue the third party in its own name, or in the name of the member. ODS is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

11.3.5 Right of Recovery

In addition to its subrogation rights, ODS may, at its sole discretion and option, ask that a member, and his or her attorney, if any, protect its reimbursement rights. If ODS elects to proceed under this section, the following rules apply:

a. The member holds any rights of recovery against the third party in trust for ODS, but only for the amount of benefits ODS paid for that illness or injury.

b. ODS is entitled to receive the amount of benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the third party. This is so regardless of whether the third party admits liability or asserts that the member is also at fault. In addition, ODS is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. If, and only if, ODS asks the member, and his or her attorney, to protect its reimbursement rights under this section, then the member may subtract from the money to be paid back to ODS, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

d. ODS may ask the member to sign an agreement to abide by the terms of this section. If ODS elects to proceed under this section it will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

e. This right of recovery includes the full amount of the benefits paid, or pending payment by ODS, out of any recovery made by the member from the third party, including, without limitation, any and all amounts from the first dollars paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. ODS' recovery rights will not be reduced due to the member's own negligence.

f. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by ODS, the member shall seek recovery of such future expenses in any third party claim.

11.3.6 Motor Vehicle Accidents

Any expense for injury or illness that results from a motor vehicle accident and is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by ODS.

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with ODS, and if motor vehicle insurance has not yet paid, then ODS may advance benefits, subject to the rights and remedies outlined in sections 11.3.2.2 and 11.3.2.3, and subject to the next paragraph.

In addition to the rights and remedies outlined in sections 11.3.2.2 and 11.3.2.3, in third party claims involving the use or operation of a motor vehicle, ODS, at its sole discretion and option, is entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

11.3.7 Additional Third Party Liability Provisions

In connection with ODS' rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sections, members shall do one or more of the following and agree that ODS may do one or more of the following, at its discretion:

a. If a member seeks payment by ODS of any benefits for which there may be a third party claim, the member shall notify ODS of the potential third party claim. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to ODS by the member's provider.

b. Upon request from ODS, the member shall provide all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. The member and his or her representatives shall have the obligation to notify ODS in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by ODS from the third party.

c. In order to receive an advance payment of benefits pursuant to section 11.3.2, ODS requires that any member seeking payment of benefits by ODS, and if the member is a minor or legally incapable of contracting, then the member's parent or guardian, must fill out, sign and return to ODS a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential third-party claim.

If the member has retained an attorney to represent himself or herself with respect to a third-party claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that agreement.

d. The member shall cooperate with ODS to protect its recovery rights, and in addition, but not by way of limitation, shall:

   i. Sign and deliver such documents as ODS reasonably requires to protect its rights;
   ii. Provide any information to ODS relevant to the application of the provisions of section 11.3.2, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
   iii. Take such actions as ODS may reasonably request to assist ODS in enforcing its rights to be reimbursed from third party recoveries.

e. By accepting the payment of benefits by ODS, the member agrees that ODS has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

f. The member agrees that ODS may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 11.3.2.

g. Even without the member's written authorization, ODS may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 11.3.2.

h. Section 11.3.2 applies to any member for whom advance payment of benefits is made by ODS whether or not the event giving rise to the member's injuries occurred before the member became covered by ODS.

i. If the member continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a third party, ODS will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

j. If the member or the member's representatives fail to do any of the foregoing acts at ODS' request, then ODS has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the member related to any sickness, illness, injury or dental/medical condition arising out of the event giving rise to, or the allegations in, the third party claim. In exercising this right, ODS may notify dental/medical providers seeking authorization or prior authorization of payment of benefits that all payments have been suspended, and may not be paid.

k. Coordination of benefits (where the member has dental/medical coverage under more than one plan or dental/medical insurance policy) is not considered a third party claim.

l. If any term, provision, agreement or condition of section 11.3.2 is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

SECTION 12. COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has dental coverage under more than one plan.

12.1 DEFINITIONS

For purposes of Section 12, the following definitions apply:

Plan means any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group insurance contracts and group-type contracts;
b. HMO (health maintenance organization) coverage;
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
e. Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

a. Fixed indemnity coverage;
b. Accident-only coverage;
c. Specified disease or specified accident coverage;
d. School accident coverage;
e. Medicare supplement policies;
f. Medicaid policies; or
g. Coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage described above is a separate plan. If a plan has 2 parts and COB rules apply to only one of the 2, each of the parts is treated as a separate plan.

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member 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 member is not an allowable expense.
The following are examples of expenses that are **not** allowable expenses:

a. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second opinions or prior authorization of services, or because the member has a lower benefit due to not using an in-network provider;
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member 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;
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
d. If a member 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 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.

This Plan is the part of this group policy that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing dental benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a plan that provides dental benefits to covered persons primarily in the form of services through a network 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 an in-network provider.

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.

12.2 HOW COB WORKS

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

The **Primary Plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **Secondary Plan** (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

12.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan which covers the member as a dependent.
b. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the member is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, 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 healthcare expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
        A. The plan covering the custodial parent;
        B. The plan covering the spouse or registered domestic partner of the custodial parent;

C. The plan covering the non-custodial parent; and then
D. The plan covering the spouse or registered domestic partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

e. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

f. **COBRA or State Continuation Coverage.** If a member 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 member as an employee, member of an organization, primary insured, or retiree or as a dependent of an employee, member of an organization, primary insured, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, primary insured, or retiree (non-dependent) longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

h. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

12.4 EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental 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 claim do not exceed the total allowable expense for that claim. 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 dental coverage.

If a member is enrolled in 2 or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

12.5 ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. ODS 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 member. ODS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give ODS any facts it needs to apply those rules and determine benefits payable.

12.6 FACILITY OF PAYMENT

If another plan makes payments this Plan should have made under this coordination provision, this Plan can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and this Plan will be released from liability regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

12.7 RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment 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 member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 13. MISCELLANEOUS PROVISIONS

The following describes other procedures and policies in effect when processing claims.

13.1 REQUEST FOR INFORMATION

When necessary to process claims, ODS may require a member to submit information concerning benefits to which he or she is entitled. ODS may also require a member to authorize any provider to give ODS information about a condition for which a member claims benefits.

13.2 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of a member's protected health information is of extreme importance to ODS. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. ODS uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. ODS does not sell this information. The Notice of Privacy Practices provides more information about how ODS uses members' information. A copy of the notice is available on ODS' website by following the HIPAA link or by calling ODS at 503-243-4492.

13.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on ODS.

13.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If ODS makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, ODS has the right to recover the payment from the person paid or anyone else who benefited from it, including a dentist or provider of services. ODS' right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the payment was not made on that member's behalf.

13.5 CONTRACT PROVISIONS

OEBB policy with ODS and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained herein. This handbook and the policy plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

13.6 WARRANTIES

All statements made by OEBB or a member, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless contained in a written form and signed by OEBB or the member, a copy of which has been given to OEBB or to the member or the member's beneficiary.

13.7 LIMITATION OF LIABILITY

ODS shall incur no liability whatsoever to any member concerning the selection of dentists to render services hereunder. In performing or contracting to perform dental service, such dentists shall be solely responsible, and in no case shall ODS be liable for the negligence of any dentist rendering such services. Nothing contained in the Plan shall be construed as obligating ODS to render dental services.

13.8 PROVIDER REIMBURSEMENTS

Under state law, providers contracting with ODS to provide services to members agree to look only to ODS for payment of the part of the expense which is covered by the Plan and may not bill the member in the event ODS fails to pay the provider for whatever reason. The provider may bill the member for applicable copayments or coinsurance and deductibles or non-covered expenses except as may be restricted in the provider contract.

13.9 INDEPENDENT CONTRACTOR DISCLAIMER

ODS and participating dentists are independent contractors. ODS and participating dentists do not have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a participating dentist's provision of dental care to ODS members may be deemed to exist or be construed to exist between ODS and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and ODS does not control the detail, manner or methods by which a participating dentist provides care.

13.10 NO WAIVER

Any waiver of any provision of the Plan, or any performance under the Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of ODS in exercising any right, power or remedy provided in the Plan, including, without limitation, a delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

13.11 GROUP IS THE AGENT

OEBB is the members' agent for all purposes under the Plan. OEBB is not the agent of ODS.

13.12 GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon.

13.13 WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

13.14 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against ODS by a member or any third party must be filed in court within 3 years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

SECTION 14. CONTINUATION OF DENTAL COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

14.1 FAMILY AND MEDICAL LEAVE

If the participating organization grants a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA), the following rules will apply:

a. Affected members will remain eligible for coverage during a FMLA leave.
b. A subscriber's rights under FMLA will be governed by that statute and its regulations.
c. If members elect not to remain enrolled during a FMLA leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the policy will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.

14.2 LEAVE OF ABSENCE

If granted a non-FMLA leave of absence by the participating organization, a subscriber may continue coverage for up to 3 months. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the participating organization at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the participating organization. A leave can be granted for any reason acceptable to the participating organization, including disability and maternity.

14.3 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the participating organization, directly to the union or trust, and the union or trust must continue to pay ODS the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage;
b. A subscriber accepts full-time employment with another employer;
c. A subscriber otherwise loses eligibility under the Plan.

14.4 RETIREES

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on retiree continuation.

14.5 OREGON CONTINUATION COVERAGE FOR SPOUSES AND DOMESTIC PARTNERS AGE 55 AND OVER

14.5.1 Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group dental insurance policies to offer enrolled spouses and domestic partners the opportunity to request a temporary extension of dental insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation").

55+ Oregon Continuation only applies to employers with 20 or more employees. ODS will provide 55+ Oregon Continuation coverage to those members who elect coverage under ORS 743.600 to 743.602, subject to the following conditions:

a. Other than the inclusion of domestic partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
b. ODS will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice, election, or other requirements outlined in the following sections; and
c. As the Plan Administrator, OEBB is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEBB fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. OEBB shall be responsible for such premiums.

14.5.2 Eligibility Requirements for 55+ Oregon Continuation Coverage

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber;
b. The spouse or domestic partner is 55 years of age or older at the time of such event; and
c. The spouse or domestic partner is not eligible for Medicare.

14.5.3 Notice And Election Requirements For 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or partnership, a legally separated or divorced spouse, or a legally separated or former domestic partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give OEBB written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse or a legally separated or former domestic partner seeking coverage.

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the participating organization shall give the designated third party administrator, if any, written notice of the death and the mailing address of the surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), OEBB or its third party administrator shall provide notice to the surviving, legally separated or divorced spouse or the surviving, legally separated or former domestic partner, that coverage can be continued, along with an election form. If OEBB or its designated third party administrator fails to notify the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, within the required 14 days (or 44 days if there is no third party administrator), premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, must return the election form within 60 days after the form is mailed. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

14.5.4 Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, to the participating organization or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

14.5.5 When 55+ Oregon Continuation Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following:

a. The failure to pay premiums when due, including any grace period allowed by the Plan;
b. The date that the Plan terminates, unless a different group policy is made available;
c. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes insured under any other group dental plan;
d. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, remarries or registers another domestic partnership under the Oregon Family Fairness Act and becomes covered under another group dental plan; or
e. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes eligible for Medicare.

14.6 COBRA CONTINUATION COVERAGE

13.6.1 Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of section 14.3, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the subscriber and the subscriber's spouse and dependent children. The Plan Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration. Specific qualifying events are listed below.

ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

a. Other than the exception on domestic partner coverage, ODS will offer no greater COBRA rights than the COBRA statute requires;
b. ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election, or other requirements outlined below; and
c. ODS will not provide COBRA coverage if the participating organization or Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the participating organization or Plan Administrator otherwise fails to comply with any of the requirements outlined below; and

d. ODS will not provide a disability extension if the participating organization or Plan Administrator fails to notify ODS within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

14.6.2 Qualifying Events

a. **Subscriber.** A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include, but is not limited to, misrepresenting immigration status to obtain employment), or a reduction in hours.

b. **Spouse.** The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

i. The death of the subscriber;
ii. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the participating organization;
iii. Divorce or legal separation from the subscriber; or
iv. The subscriber becomes entitled to Medicare.

(Also, if a subscriber eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

c. **Children.** A dependent child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

i. The death of the subscriber;
ii. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the participating organization;
iii. Parents' divorce or legal separation;
iv. The subscriber becomes entitled to Medicare; or
v. The child ceases to be a "dependent " under the Plan.

d. **Domestic Partners.** A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

14.6.3 Other Coverage

The right to elect continuation coverage shall be available to persons who are entitled to Medicare at the time of the election or are covered under another group dental plan at the time of the election.

14.6.4 Notice and Election Requirements

Qualifying Event Notice. The Plan provides that a member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the member(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. When the Plan Administrator receives a timely qualifying event notice, members will be notified of their right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, members will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the Plan Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental insurance coverage for all members will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

14.6.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, under the law, they are responsible for all premiums for continuation coverage except for members who qualify for premium reduction under any applicable federal law. The first payment for continuation coverage is due within 45 days after a qualified beneficiary provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the Plan Administrator if hand delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. ODS will not send a bill for any payments due. The qualified beneficiary is responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

14.6.6 Length of Continuation Coverage

If COBRA is elected, the participating organization will provide the same coverage as is available to similarly situated members under the Plan.

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the subscriber) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

14.6.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The Plan Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure of the qualified beneficiary to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Plan Administrator is notified in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination;
b. the date of the subscriber's termination of employment or reduction of hours; and
c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours.

A qualified beneficiary must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the subscriber's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, he or she must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal

separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if the Plan Administrator is notified in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the Plan Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 14.5).

14.6.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered a qualified beneficiary. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The subscriber or a family member must notify the participating organization within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the participating organization in a timely fashion, the child will not be eligible for continuation coverage.

14.6.9 Special Enrollment and Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated members who are not enrolled in COBRA. A qualified beneficiary may add newborns, new spouses, or domestic partners, and adopted children (or children placed for adoption) as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

14.6.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time;
b. a qualified beneficiary becomes covered, after electing COBRA, under another group dental plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
c. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA.;
d. the participating organization ceases to provide any group dental plan for its employees; or
e. during a disability extension period (see section 14.3.7)), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

Questions about COBRA should be directed to the Plan Administrator. The Plan Administrator should be informed of any address changes.

14.6.11 The American Recovery and Reinvestment Act of 2009 as amended

This Act provides for premium reductions for continuation coverage under COBRA. Eligible members pay 35% of their COBRA premiums. The premium reduction applies to periods of dental coverage beginning on or after February 17, 2009 and continues up to 15 months for those eligible for COBRA due to an involuntary termination of employment that occurred during the period beginning September 1, 2008 and ending May 31, 2010. Questions about this Act and related notice requirements should be directed to the Plan Administrator.

14.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active, eligible employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the participating organization if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of his or her military service for a leave of 30 days or less;
b. Within 14 days of completing military service for a leave of 31 to 180 days; or
c. Within 90 days of completing military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

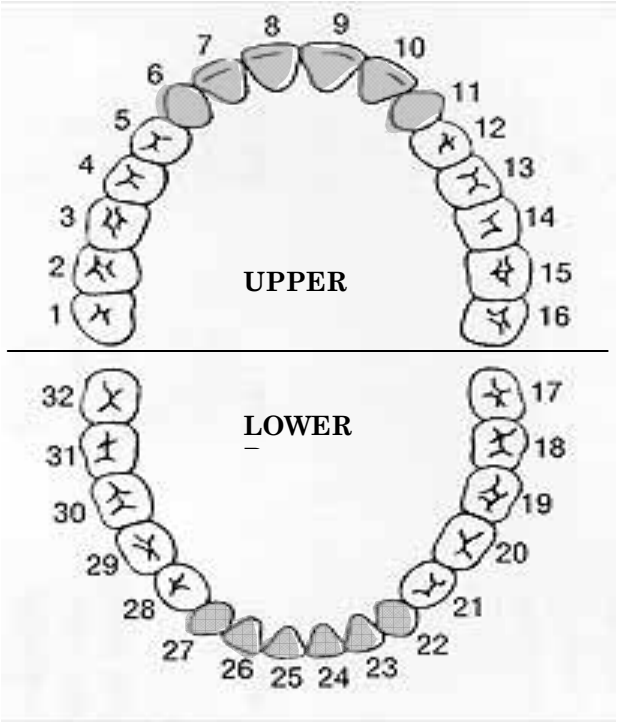
When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Participating District).

SECTION 15. RESERVED FOR FUTURE USE

SECTION 16. EXHIBITS

16.1 TOOTH CHART – THE PERMANENT ARCH

RIGHT



LEFT

Note: Anterior teeth are shaded gray.

The Permanent Arch		
Tooth #		**Description of Tooth**
Upper	**Lower**	
1	17	3rd Molar (wisdom tooth)
2	18	2nd Molar (12-yr molar)
3	19	1st Molar (6-yr molar)
4	20	2nd Bicuspid (2nd premolar)
5	21	1st Bicuspid (1st premolar)
6	22	Cuspid (canine/eye tooth)
7	23	Lateral Incisor
8	24	Central Incisor
9	25	Central Incisor
10	26	Lateral Incisor
11	27	Cuspid (canine/eye tooth)
12	28	1st Bicuspid (1st premolar)
13	29	2nd Bicuspid (2nd premolar)
14	30	1st Molar (6-yr molar)
15	31	2nd Molar (12-yr molar)
16	32	3rd Molar (wisdom tooth)

16.2 EXAMPLE OF HOW THE PLAN PAYS

The payments on specific claims will be based on the individual agreement between ODS and the dentist. Members seeing a participating Premier dentist may have a lower member responsibility, as some disallowed charges must be written off by the dentist. For purposes of this example, it is assumed any deductible has been met and the benefit is 80% of the allowed charge. Allowed charge is based on the maximum plan allowance.

Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Copay	Paid	Mbr. Resp.
1/01/11	D2150 Amalgam Filling	30	$120.00	$20.00*	$0.00	$20.00	$100.00	$20.00	$80.00	$20.00
1/01/11	D9215 Local Anesthesia	--	$50.00	$50.00**	$0.00	$50.00	$0.00	$0.00	$0.00	$0.00
Totals:	---	---	$170.00	$70.00	$0.00	$70.00	$100.00	$20.00	$80.00	$20.00

Total Out of Pocket Expense

Reason Code: * THE FEE CHARGED EXCEEDS THE MAXIMUM ALLOWANCE
** A SEPARATE, ADDITIONAL PAYMENT IS NOT PROVIDED FOR LOCAL ANESTHESIA.

Non-Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Copay	Paid	Mbr. Resp.
1/01/11	D2150 Amalgam Filling	30	$120.00	$20.00*	$0.00	$0.00	$100.00	$20.00	$80.00	$40.00
1/01/11	D9215 Local Anesthesia	--	$50.00	$50.00**	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00
Totals:	---	---	$170.00	$70.00	$0.00	$0.00	$100.00	$20.00	$80.00	$90.00

Total Out of Pocket Expens

Reason Code: * THE FEE CHARGED EXCEEDS THE MAXIMUM ALLOWANCE.
** A SEPARATE, ADDITIONAL PAYMENT IS NOT PROVIDED FOR LOCAL ANESTHESIA.

The amount a member would save, in this example, by seeing a Participating Premier Dentist is $70.00

Insurance products provided by Oregon Dental Service

601 SW Second Avenue
Portland, OR 97204

Member Inquiries
Portland 503-265-2910
Toll-Free 866-923-0410
TDD/TTY 800-433-6313
En Español: 503-433-631
Llamado Gratis: 888-786-7461

www.odscompanies.com/oebb

DELTA DENTAL