DELTA DENTAL®

Dental Group Plan

Clackamas County
(Peace Officers' Association)

Delta Dental Premier Plan
Effective Date: January 1, 2016
Group No. 10000174

Powered by moda

Oregon Dental Service (doing business as Delta Dental Plan of Oregon) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

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SECTION 1. WELCOME

This handbook describes the main features of the Group's dental plan ("the Plan"), but does not waive any of the conditions of the Plan as set out in the Plan Document.

The Plan is self-funded and the Group has contracted with Delta Dental to provide claims and other administrative services. Delta Dental is part of the Moda Health organization.

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

Delta Dental reserves the right to monitor telephone conversations and e-mail communications between its employees and its members for legitimate business purposes as determined by Delta Dental.

This handbook may be changed or replaced at any time, by the Group or Delta Dental, without the consent of any member. The most current handbook is available on myModa, accessed through the Moda Health website. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

1.1 MEMBER RESOURCES

Moda Health Website (log in to **myModa**)
www.modahealth.com

Dental Customer Service Department
Portland 503-265-2965; Toll-free 888-217-2365
En Español 503-265-2963; Llamado gratis 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Delta Dental
P.O. Box 40384
Portland, Oregon 97240

SECTION 2. USING THE PLAN

Delta Dental plans are easy to use and cost effective. If members choose a participating Delta Dental Premier from the Delta Dental Premier Dental Directory (available on myModa by using "Find Care"), all of the paperwork takes place between Delta Dental and the dentist's office. More than 90% of all licensed dentists in Oregon are participating Delta Dental Premier dentists. For travelers and employees outside Oregon, Delta Dental 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 for participating Delta Dental Premier dentists and non-participating dentists or dental care providers. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

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

For expensive treatment plans, Delta Dental 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 benefits 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 Customer Service.

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

SECTION 3. DEFINITIONS

Affidavit of Domestic Partnership means a signed document that attests the subscriber and one other eligible person meet the criteria in the definition of unregistered domestic partner.

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 13)

Bicuspid is a premolar tooth, between the front and back teeth. (tooth chart in Section 13)

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 or dental office and cemented into the tooth.

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

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

Cost Sharing is the share of costs a member must pay when receiving a covered service, including deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network providers or the cost of non-covered services.

Covered Service is a service that is specifically described as a benefit of the Plan.

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.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. References to Delta Dental as paying claims or issuing benefits mean that Delta Dental processes a claim and the Group reimburses Delta Dental for any benefit issued.

Dentally Necessary means services that:

a. are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. are appropriate with regard to standards of good dental practice in the service area;
c. have a good prognosis
d. 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

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 licensed dentist, 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.

Dependent means any person who is or may become eligible for coverage under the terms of the Plan because of a relationship to a subscriber.

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner as follows:

a. **Registered Domestic Partner** means a person joined with the subscriber in a domestic partnership that has been registered under the laws of any federal, state or local government
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group's affidavit of domestic partnership

Eligible Employee means any employee or former employee who has met the eligibility requirements to be enrolled on the Plan.

Emergency means services immediately required to relieve severe pain, swelling or bleeding, or required to avoid jeopardizing the member's health.

The **Group** is Clackamas County, the organization that has contracted with Delta Dental to provide claims and other administrative services. It also means the Plan Sponsor.

Group Health Plan means any plan, fund or program established and maintained by the Group 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 Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with Delta Dental/Delta Dental. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental's Dental Consultant who determines a comparable code to the one billed. For non-participating dentists or dental care providers, the maximum amount is based on a per service average allowance of the participating Delta Dental Premier dentists' filed fees. When using a non-participating dentist, any amount above MPA is the member's responsibility.

Member means a subscriber, dependent of a subscriber or a person otherwise eligible for the Plan who has enrolled for coverage under the terms of the Plan.

Non-participating Dentist or Dental Provider means a licensed dental provider who has not agreed to the terms and conditions established by Delta Dental that participating Delta Dental Premier dentists have agreed to.

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).

The **Plan** is the dental benefit plan sponsored and funded by the Group.

Plan Sponsor means the Group.

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 13)

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 employee or former employee who is enrolled in the Plan.

Veneer 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.

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

SECTION 4. BENEFITS AND LIMITATIONS

The Plan covers the services listed when performed by a dentist or dental care provider, denturist, or registered hygienist, and 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). Delta Dental' dental consultants and dental director shall determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

Benefits are determined based on a calendar year (January 1 through December 31) or portion thereof.

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 6 for exclusions.

Deductible: None

Maximum payment limit: $1,500
Per member per year, or portion thereof
All covered services apply to maximum payment limit.

4.1 CLASS I:

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST YEAR A MEMBER IS COVERED

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

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

4.1.1 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 twice per year.
   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 12-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.

4.1.2 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 twice per year†.
   ii. Topical application of fluoride is covered twice per year for members age 18 and under. For members age 19 and over, topical application of fluoride is covered twice per calendar year if there is recent history of periodontal surgery 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 or missing permanent teeth 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 5).

4.2 CLASS II:

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST YEAR A MEMBER IS COVERED

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

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

4.2.1 Restorative

a. **Restorative Services:**
   i. Amalgam fillings and composite fillings for the treatment decay.
   ii. Stainless steel crowns

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 4.3.1.
   iv. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered, except as provided under Class II, Miscellaneous (oral sedatives and nitrous oxide).
   v. Replacement of a stainless steel crown by the same dentist within 24 months of placement is not covered. The replacement is included in the charge for the original crown.

4.2.2 Oral Surgery

a. **Oral Surgery Services:**
   i. Extractions (including surgical),
   ii. Other minor surgical procedures.

b. **Oral Surgery Limitations:**
   i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
   ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
   iii. Brush biopsy is covered twice per year. Benefits are limited to the sample collection and does not include coverage for pathology (lab) services.

4.2.3 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 to 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.

4.2.4 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 are limited to once every 6 months. Periodontal cleaning up to 4 times per year when there is a diagnosis of periodontal disease.
   ii. A separate charge for post-operative care done within 6 months following periodontal surgery is not covered.
   iii. 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.

4.2.5 Anesthesia

a. **Anesthesia Services:**
   General anesthesia or IV sedation is covered
   i. In conjunction with covered surgical procedures performed in a dental office.
   ii. When necessary due to concurrent medical conditions.

4.3 CLASS III

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST YEAR A MEMBER IS COVERED

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

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

4.3.1 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 5-year period on any tooth. See section 4.2.1 for limitations on buildups.
   ii. Crowns for patients under age 16 are not covered. However, crowns for patients under age 16 may be covered upon review for medical necessity.
   iii. 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.
   iv. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

4.4 CLASS IV:
COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

There is no "10% increase" provision.

4.4.1 Prosthodontic

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

b. **Prosthodontic Limitations:**
   i. A bridge or a 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 being decayed or broken.
   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. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:
      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 over the lifetime of the implant.

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.

4.4.2 Other

a. Other Services:

i. Athletic mouthguard
ii. Orthodontia for correcting malocclusioned teeth

b. Other Limitations:

i. An athletic mouthguard is covered once per year for members age 15 and under and once every 2 years age 16 and over.
ii. Orthodontia is covered only for children. Treatment must begin prior to their 17th birthday.
iii. The plan will pay 50% toward covered orthodontic services, up to the orthodontic lifetime maximum of $3,000 per member.
iv. Payment for orthodontia will end when treatment stops 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, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount
ii. Repair or replacement of an appliance furnished under the Plan is not covered
iii. If the Plan has a deductible, it does not apply to orthodontic services.

4.5 General Limitation – Optional Services

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

4.6 Non-Participating Dentists

The amounts payable for services of a non-participating dentist or dental care provider 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 5. 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. Studies have indicated a relationship between periodontal disease, bacteria in the mouth, and various health problems including pre-term, low birth weight babies and diabetes.

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

The Plan offers a program that provides additional cleanings (prophylaxis or periodontal maintenance) for members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in Section 8.

5.1.1 Diabetes

For members with diabetes, elevated blood sugar levels can have a negative effect on 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. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

Diabetic members are eligible for a total of 4 cleanings per year.

5.1.2 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. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact Delta Dental Customer Service or complete and return the Oral Health, Total Health enrollment form found on myModa. Members with diabetes must include proof of diagnosis.

SECTION 6. 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 dentist or dental care provider.

Anesthesia or Sedation
General anesthesia and/or IV sedation except as stated in section 4.2.5.

Anesthetics, Analgesics, Hypnosis, and Medications
Including nitrous oxide, local anesthetics or any other prescribed drugs

Benefits Not Stated
Services or supplies not specifically described in this handbook as covered services.

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service, except as stated in section 9.1.

Congenital or Developmental Malformations
Including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth). Except orthodontia for treatment of cleft palate may be covered.

Cosmetic Services

Duplication and Interpretation of X-rays

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures.

Facility Fees
Including additional fees charged by the dentist for hospital, extended care facility or home care treatment.

Gnathologic Recordings

Illegal Acts, Riot or Rebellion
Services and supplies for treatment of an injury or condition caused by or arising out of a member's voluntary participation in a riot or arising directly from an illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions or Training
Including plaque control and oral hygiene or dietary instruction.

Localized Delivery of Antimicrobial Agents

Missed Appointment Charge

Never Events
Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

Orthodontia
Except as provided for children

Periodontal Charting

Precision Attachments

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

Self-Treatment
Services provided by a member to herself or himself

Services on Tongue, Lip, or Cheek

Service Related Conditions
Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war

Services Otherwise Available
Including those services or supplies:

a. compensable under workers' compensation or employer's liability laws
b. provided by any city, county, state or federal law, except for Medicaid coverage
c. 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
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 9.3.2).

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ).

Treatment After Coverage Terminates
Except for Class III 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

Treatment Not Dentally Necessary
Including services:

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

SECTION 7. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 8.5).

7.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

a. is a regular full-time or part-time employee, an employee in a job share position, a non-represented job share employee with benefit dollar allowance, or a retiree of Clackamas County
b. is not a seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor or leased worker
c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Group on a regularly scheduled basis working the minimum number of hours per week required for that job position
e. has satisfied any orientation and/or eligibility waiting period

Spouses or domestic partners who are both eligible employees may each enroll as a subscriber or one may be covered as an enrolled dependent of the other.

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws. Members should check with the Group's benefits manager to find out whether they qualify for this provision.

7.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are also subject to the Plan's child age limit.

For purposes of determining eligibility, the following are considered "children":

a. The natural, adopted or foster child of a subscriber or a subscriber's spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has sustained a disability rendering him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have arisen, and the information below must be received, before the child's

26th birthday. Social Security Disability status does not guarantee coverage under this provision. Delta Dental will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Recent hospitalization records (e.g., history and physical, discharge summary) if applicable
d. Disability information from prior carrier

Delta Dental will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Delta Dental will be required on an ongoing basis except in cases where the disability is certified to be permanent.

7.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that the applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

7.4 NEW DEPENDENTS

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

If a subscriber files an Affidavit of Domestic Partnership with the Group, the unregistered domestic partner and his or her children are eligible for coverage.

A member's newborn child will automatically be enrolled for 31 days after birth. Adopted children are automatically enrolled for the first 31 days from the date of the adoption decree. If a child is placed with the subscriber pending the completion of adoption proceedings, and the subscriber has assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption, that child will be enrolled for the first 31 days from the date of placement. To obtain coverage, an online enrollment application with the group must be submitted within those 31 days. If the enrollment application is not received, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply during the first 31 days of coverage for newborn or adopted children. If payment is required but not received, the dependent will not be covered.

SECTION 8. ENROLLMENT

8.1 ENROLLING ELIGIBLE EMPLOYEES

Application for coverage may be submitted online for the eligible employee and any dependents to be enrolled and must be filed with the Group within 15 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period.

The subscriber must notify the Group of any change of address.

8.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, just complete the online enrollment application with the Group within 60 days of their eligibility.

The subscriber must notify Delta Dental through the Group if family members are added or dropped from coverage, even if it does not affect premiums.

8.3 OPEN ENROLLMENT

Eligible employees and/or any eligible dependents who are not enrolled within 15 days of first becoming eligible must wait for the next open enrollment period to enroll unless they meet one of the eligibility requirements described in section 13.4. Open enrollment occurs once a year at renewal.

8.4 SPECIAL ENROLLMENT RIGHTS

8.4.1 Loss of Other Coverage

If coverage is declined when initially eligible because of other dental coverage, an eligible employee or any dependent(s) may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group dental plan or had dental coverage at the time coverage was previously offered;
b. He or she stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined;
c. He or she requests such enrollment not later than 60 days after the previous coverage ended; and
d. One of the following events has occurred:

    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; this includes reaching the lifetime maximum while on COBRA coverage.

ii. His or her prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
   A. legal separation or divorce
   B. loss of dependent status per plan terms
   C. death
   D. termination of employment
   E. reduction in the number of hours of employment
   F. the plan ceasing to offer coverage to a group of similarly situated persons
   G. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan
   H. termination of the benefit package option, and no substitute option is offered

iii. The employer contributions toward his or her other coverage were terminated. (If employer contributions cease, the eligible employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)

iv. His or her 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.

8.4.2 Eligibility for Premium Subsidy

If an eligible employee or dependent 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.

8.4.3 Family Status Changes

Benefits are regulated by Section 125 of the Internal Revenue Code (IRC). This allows an eligible employee to change enrollment selections only during Open Enrollment and/or as a result of a qualified Family Status Change.

a. All enrollment changes must be completed through the Risk & Benefits Division
b. To make changes, the eligible employee must complete a Notice of Change in Family Status and required enrollment forms, and provide the required documentation within 60 days of the qualifying event. If the 60-day deadline is not met, the eligible employee will not be able to add any family members until the next Open Enrollment
c. Changes are effective the first of the month following the Family Status Change or receipt of required forms and documents, whichever is later. Dental coverage for new children is automatic only for the first 31 days from the date of birth or adoption. Claims received after the 31st day will not be paid until enrollment forms are completed and processed

8.5 WHEN COVERAGE BEGINS

Coverage will begin on the first day of the month following two months of continuous employment.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group will begin on the first day of the month following receipt of the online enrollment forms.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

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

8.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

8.6.1 Termination of the Group Plan

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

8.6.2 Termination by a Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving written notice to the Group, unless the coverage election is considered irrevocable for the plan year (such as when employee share of premium is withheld from paycheck on pretax basis). Coverage ends on the last day of the month through which premiums are paid.

8.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see section 12.2). The Group must notify Delta Dental of any continuation of coverage and appropriate premiums must be paid along with the Group's regular monthly payment.

8.6.4 Loss of Eligibility, Layoff or Reduction in Hours of Employment

If employment terminates, coverage will end on the last day of the month in which termination occurs, unless a member chooses to continue coverage (see Section 12).

If a subscriber is laid-off by the Group and returns to active work within 6 months of being laid off, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 6 months the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the group plan on the date the subscriber qualifies and coverage will begin on that date provided the necessary premiums for coverage are paid.

The Group must notify Delta Dental that the subscriber is rehired or of an increase in hours and the necessary premiums for coverage must be paid. All Plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

An employee who has continuously participated in COBRA continuation coverage during a layoff, and is reinstated to employment within eighteen (18) months from layoff, will have the benefit waiting period waived. This applies to all lines of coverage and any type of layoff (economic or medical layoff).

8.6.5 Loss of Eligibility by Dependent

Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or the domestic partnership no longer meets the requirements of the Affidavit of Domestic Partnership filed with the Group. Coverage ends for an enrolled child on the last day of the month in which the child reaches age 26, unless the child continues coverage as provided under the Plan (see Section 12).

All enrolled dependents have the right to continue coverage in their own names when their coverage under the Plan ends.

8.6.6 Rescission

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by a member, which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. Should the Plan terminate coverage under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of any affiliates.

8.6.7 Continuing Coverage

Information is in Continuation of Dental Coverage (Section 12).

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION AND PAYMENT OF CLAIMS

9.1.1 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. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

9.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a 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 myModa. The Explanation of Benefits will indicate if a claim has been paid, denied, or accumulated 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 Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 14.1.1.

9.1.3 Claim Inquiries

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

9.1.4 Time Frames for Processing Claims

If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond Delta Dental' control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then complete its processing and send an EOB to the member no more than 45 days after receiving the claim. If additional information is needed to complete processing of the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 14.1.1.

9.2 APPEALS

9.2.1 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Delta Dental, in the form of a letter or an Explanation of Benefits (EOB), of 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 one based on a determination of a person's eligibility to participate in the Plan and one 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.

Appeal is a written request by a member or his or her representative for Delta Dental to review an adverse benefit determination.

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

9.2.2 Time Limit for Submitting Appeals

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.

9.2.3 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. Delta Dental's response time to an appeal is based on the nature of the claim as described below.

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or 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).

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.

9.2.4 First Level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Delta Dental Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Delta Dental Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Delta Dental will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not previously involved in the original determination. The investigation will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, Delta Dental 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.

9.2.5 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 submitted in writing within 60 days of the date of Delta Dental' action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations. 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 14.2.4. Delta Dental will notify the member in writing of the decision, including the basis for the decision.

9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

Sometimes dental expenses may be the responsibility of someone other than the Plan.

9.3.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 10.

9.3.2 Third-Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which benefits or healthcare costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member, the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed in full from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in section 14.3.2. The Plan 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, the Plan's right of recovery or subrogation as discussed in this section. Delta Dental has discretion to interpret and construe these recovery and subrogation provisions.

9.3.2.1 Definitions:

For purposes of section 14.3.2, the following definitions apply:

Benefits means any amount paid by the Plan, or submitted to Delta Dental for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Recovery Funds means any amount recovered from a third party.

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, personal injury protection (PIP) coverage, and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such action) by or on behalf of a member.

9.3.2.2 Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

9.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply:

a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.
b. The Plan is entitled to receive the amount of benefits it has paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Plan 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. The Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan 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. The Plan's recovery rights will not be reduced due to the member's own negligence.

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

f. In third party claims involving the use or operation of a motor vehicle, the Plan, 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, or under applicable state law.

9.3.2.4 Additional Provisions

Members shall comply with the following and agree that the Plan may do one or more of the following at its discretion:

a. The member shall cooperate with the Plan to protect its recovery rights, including by:

    i. Signing and delivering any documents the Plan reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has

retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned

ii. Providing any information to Delta Dental relevant to the application of the provisions of section 14.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments

iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.

iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing its third party recovery rights

b. The member and his or her representatives are obligated to notify Delta Dental 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 the Plan from the third party

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

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 14.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 14.3.2.

f. Section 14.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan 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.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim. The Plan may notify dental/medical providers seeking authorization of payment of benefits that all payments have been suspended, and may not be paid.

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

SECTION 10. COORDINATION OF BENEFITS

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

10.1 DEFINITIONS

For purposes of Section 15, 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 or individual 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
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
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.

Allowable expense means a dental expense, including cost sharing, 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, 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 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 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 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 plan funded by the Group and it 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 plan providing dental benefits is separate from this Plan. A plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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.

10.2 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 any other plans pay. 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 that pays 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.

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 this Plan 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

10.3 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 Domestic Partners, or Living Together.** If the member is a dependent child whose parents are married, registered domestic partners, or are living together whether or not they have ever been married or registered domestic partners, 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'.)
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 domestic partners, 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 is responsible, the 'birthday rule' described above applies.

iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
    A. Custodial parent;
    B. Spouse or domestic partner of the custodial parent;
    C. Non-custodial parent;
    D. Spouse or domestic partner of the non-custodial parent.

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.

e. **Dependent Child Covered by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's plans began on the same day, the birthday rule will apply.

f. **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.

g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, 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.

h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

i. **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.

10.4 EFFECT ON THE BENEFITS OF THIS PLAN

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 shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

SECTION 11. MISCELLANEOUS PROVISIONS

11.1 Right to Collect and Release Needed Information

In order to receive benefits, the member must give or authorize a provider to give the Plan any information needed to pay benefits. The Plan may release to or collect from any person or organization any needed information about the member.

11.2 Confidentiality of Member Information

Keeping a member's protected health information confidential is very important to the Group. Protected health information includes enrollment, claims, and medical and dental information. Such information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses such information. Delta Dental, as the third party administrator, is required to adhere to these same practices. Members can contact the Group regarding additional questions about the privacy of their information beyond that provided in the Notice of Privacy Practices.

11.3 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 Delta Dental nor the Plan, except that Delta Dental shall pay amounts due under the Plan directly to a provider upon a member's written request.

11.4 Recovery of Benefits Paid by Mistake

If the Plan 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, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

11.5 Correction of Payments

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

11.6 CONTRACT PROVISIONS

The agreement between the Group and Delta Dental including the handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the agreement plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition 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.

11.7 WARRANTIES

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

11.8 LIMITATION OF LIABILITY

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

11.9 PROVIDER REIMBURSEMENTS

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

11.10 INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and participating dentists are independent contractors. Delta Dental 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 members may be deemed or construed to exist between Delta Dental and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and Delta Dental does not control the detail, manner or methods by which a participating dentist provides care.

11.11 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. If Delta Dental delays or fails to exercise any right, power or remedy provided in the Plan, including a delay omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

11.12 Group is the Agent

The Group is the members' agent for all purposes under the Plan. The Group is not the agent of Delta Dental.

11.13 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.

11.14 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.

11.15 Time Limits for Filing a Lawsuit

Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any Third Party, must be filed in court no more than 3 years after the time the claim was files (see section 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal claim in court.

SECTION 12. CONTINUATION OF DENTAL COVERAGE

IMPORTANT NOTICE

The following sections on continuation of coverage may apply. Members should check with their employer's Risk & Benefits Division to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

12.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

12.1.1 Introduction

The Plan offers enrolled spouses and domestic partners the opportunity to request a temporary extension of dental coverage for themselves and their dependents if coverage is lost due to a specific event identified in the following paragraphs.

55+ Oregon Continuation only applies to employers with 20 or more employees. The Plan will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the following conditions:

a. The Plan will offer no greater rights than ORS 743.600 to 743.602 requires
b. The Plan will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. The Group or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group or its designated third party administrator 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. The Group shall be responsible for such premiums

Note: In section 17.1 the term “domestic partner” refers only to a registered domestic partner, as defined in Section 3.

12.1.2 Eligibility

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.

12.1.3 Notice and Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a legally separated or divorced spouse or domestic partner who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

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 Group 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), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator fails to provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or 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.

12.1.4 Premiums

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 domestic partner to the Group 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.

12.1.5 When Coverage Ends

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

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan terminates coverage, unless a different group plan is made available to Group members
c. The date the member becomes insured under any other group dental plan;
d. The date the member remarries or registers another domestic partnership and becomes covered under another group dental plan
e. The date the member becomes eligible for Medicare

12.2 COBRA CONTINUATION COVERAGE

12.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. The Plan will offer no greater COBRA rights than the COBRA statute requires;
b. The Plan will not provide COBRA coverage for those members who do not comply with the notice, election or other requirements outlined below.

For purposes of section 12.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

12.2.2 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 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. Death of the subscriber
   ii. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
   iii. Divorce or legal separation from the subscriber
   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 COBRA 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.)

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or registered 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 12.1).

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

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

d. **Domestic Partners.** A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ceases immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

12.2.3 Other Coverage

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

12.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent 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 County's Risk and Benefits Division if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce): and 4) 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 given on time, continuation coverage will not be available.

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

Otherwise, members will be notified by the COBRA 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), or reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage 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.

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

12.2.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. The first payment for continuation coverage is due within 45 days after a member 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 COBRA 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. The Plan will not send a bill for any payments due. The member 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.

12.2.6 Length of Continuation Coverage

18-Month Continuation Period. In the case of a loss of coverage due to end of employment 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 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 members 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.

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death; coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

12.2.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member fails to provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members 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 member 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 COBRA 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
c. the date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours

A member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, 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 determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA 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 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 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 member 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 COBRA 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 COBRA 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 12.1).

12.2.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. 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 COBRA Administrator within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the COBRA Administrator in a timely fashion, the child will not be eligible for continuation coverage.

12.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners 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.

12.2.10 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 member becomes covered under another group dental plan
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. the Group ceases to provide any group dental plan for its employees
e. during a disability extension period (see section 17.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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 COBRA Administrator. The COBRA Administrator should be informed of any address changes.

12.3 UNIFORMED SERVICES EMPLOYMENT & 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 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 Group 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 Group).

12.4 FAMILY AND MEDICAL LEAVE

If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave
b. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations
c. If members elect not to remain enrolled during a family and medical 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 Plan 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

12.5 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the Group 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 Group. A leave can be granted for any reason acceptable to the Group.

If granted a leave of absence, a subscriber may continue coverage for up to the amount of time specified by the group. Premiums must be paid to the Group in order to maintain coverage during a leave of absence.

12.6 STRIKE OR LOCKOUT

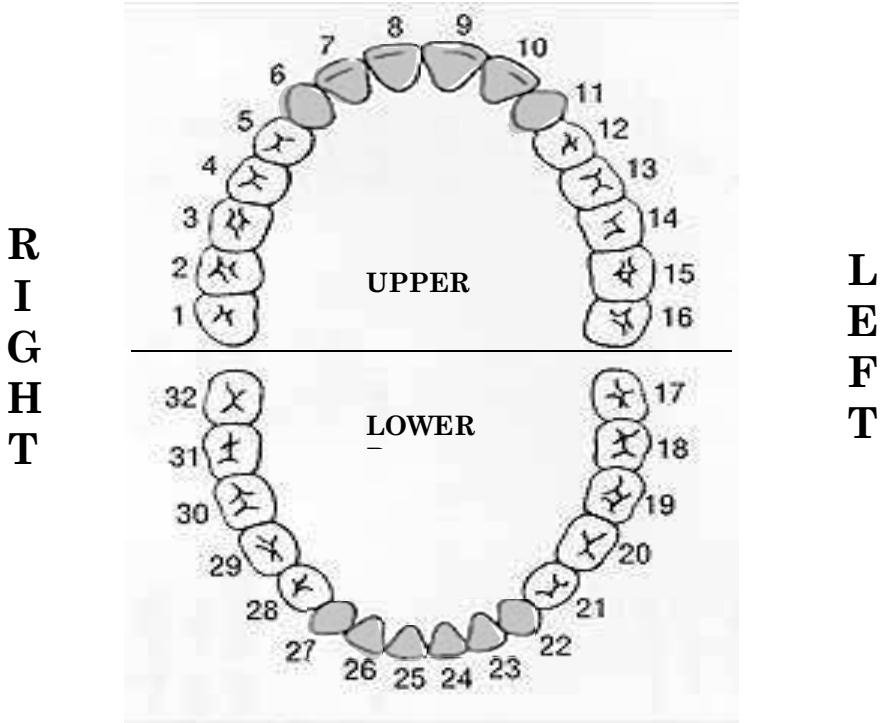
If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union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

SECTION 13. TOOTH CHART

THE PERMANENT ARCH



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)

For help, call us directly at 888-217-2363.
(En Español: 888-786-7461)

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