



GROUP DENTAL PLAN

Washington County

Delta Dental Premier Plan

Effective Date: July 1, 2011

Group No. 10000165

www.odskompanies.com



Member handbooks and more are available at www.odskompanies.com

Insurance products provided by Oregon Dental Service

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SECTION 1. WELCOME

Oregon Dental Service (ODS) was created in 1955 and was the first company in America to provide prepaid dental coverage. Today ODS is Oregon's largest, covering over 650,000 people from more than 1,400 groups.

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

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

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

Dental Customer Service Department

Portland	503-265-2965
Toll Free	888-217-2365
Relay Service	711 (for the hearing and speech impaired)
En Español	503-265-2963
Llamado Gratis	877-299-9063

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

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

SECTION 2. RESERVED FOR FUTURE USE

SECTION 3. USING THE PLAN

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

Members needing dental care may go to any dental office. However, **there are differences in reimbursement by ODS for participating Premier dentists and non-participating dentists.** An example is provided in section 14.2. While a member may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

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

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

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

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

3.1 MEMBER RESOURCES

ODS Website (log in to **myODS**)

www.odscompanies.com

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

SECTION 4. DEFINITIONS

The following are definitions of some important terms used in this handbook.

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

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 14.1)

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

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

Bicuspid is a premolar tooth, between the front and back teeth. (tooth chart in section 14.1)

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

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

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

Claim Determination Period means a calendar year (January 1 through December 31) or portion thereof.

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

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

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

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

Dentally Necessary means:

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

Note:

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

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

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

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

- a. **Registered Domestic Partner** means a person of the same sex joined with the subscriber in a domestic partnership that has been registered in Oregon according to the Oregon Family Fairness Act.
- b. **Unregistered Domestic Partner** means a person of the same sex who has entered into a partnership with the subscriber that meets the following criteria:
The domestic partner and subscriber
 - i. are at least 18 years of age;
 - ii. share a close personal relationship and are responsible for each other's welfare;
 - iii. are each other's sole domestic partners;
 - iv. are not legally married or registered under the Oregon Family Fairness Act and have not had a spouse or domestic partner within the prior 6 months. If previously married or registered, the 6 month period starts on the final date of divorce or dissolution of registration;
 - v. are not related by blood closer than would bar marriage in the State of Oregon;
 - vi. were mentally competent to contract when their domestic partnership began;
 - vii. have jointly shared the same regular and permanent residence for at least 6 months; and
 - viii. are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

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

Eligible Employee means any employee who meets the conditions of eligibility outlined in the Plan.

Enrollment Date means the date a subscriber's or dependent's coverage becomes effective under the terms of the Plan.

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

Group Eligibility Waiting Period means the period of employment with the Group that a prospective member must complete before coverage begins.

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

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

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

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

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

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

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

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

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

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

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

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

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

Posterior refers to teeth located toward the back of the mouth. (tooth chart in section 14.1)

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

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

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

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

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

SECTION 5. BENEFITS AND LIMITATIONS

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

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures.

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

Deductible: None

Maximum payment limit: \$1,500.00

Per member per calendar year, or portion thereof

All covered services (Class I, II, III) apply to maximum payment limit

5.1 CLASS I: 70% IS PROVIDED TOWARD COVERED CLASS I SERVICES IN THE FIRST CALENDAR YEAR A MEMBER IS COVERED.

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

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

5.1.1 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 once in any 6-month period*.
- ii. Complete series x-rays or a panoramic film is covered once in any 5-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.
- vi. ViziLite Plus TBlue is covered once in any 6-month period*.

5.1.2 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) is covered twice in a calendar year †.
- ii. Topical application of fluoride is covered once in any 6-month period* for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period* if there is 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 bicuspids and molars. Benefits will be limited to one sealant per tooth during any 5-year period.
- iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

*These time periods are calculated from the previous date of service.

†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see Section 6).

5.2 CLASS II: 70% IS PROVIDED TOWARD COVERED CLASS II SERVICES THE FIRST CALENDAR YEAR A MEMBER IS COVERED.

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

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

5.2.1 Restorative

a. Restorative Services:

- i. Provides amalgam fillings and composite fillings for the treatment of carious lesions (decay).

b. Restorative Limitations:

- i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
- ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.

- iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 5.3.1.
- iv. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

5.2.2 Oral Surgery

a. Oral Surgery Services:

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

b. Oral Surgery Limitations:

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

5.2.3 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 of the pulp.
- iii. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

5.2.4 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 is limited to once per quadrant in any 24-month period.
- ii. Coverage for periodontal maintenance procedure is limited to 4 times in a calendar year.
- iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
- iv. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

5.3 CLASS III: 50% IS PROVIDED TOWARD COVERED CLASS III SERVICES.

There is no “10% increase” provision.

5.3.1 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 5.2.1 for limitations on buildups.
- ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
- iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

5.3.2 Prosthodontic

a. Prosthodontic Services:

- i. Bridges,
- ii. Partial and complete dentures,
- iii. Denture relines,
- iv. Repair of an existing prosthetic device
- v. Implants

b. Prosthodontic Limitations:

- i. A bridge or denture (full or partial denture) will be covered **once in a 5-year period** and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit **in the last 5 years**.
- ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
- iv. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.

- v. Tissue conditioning is covered no more than twice per denture in a 36-month period.
- vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The Plan will also benefit:
 - A. The final crown and implant abutment over a single implant. This benefit is limited to **once per tooth or tooth space in any 5-year period**; 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 5-year period**); or
 - C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to **once per tooth or tooth space in any 5-year period**.
 - D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
 - E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, **within the previous 5 years**.
- vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
- viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

5.3.3 Other

a. Other Services:

- i. Athletic mouthguard

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.

5.4 GENERAL LIMITATION – OPTIONAL SERVICES

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

5.5 NON-PARTICIPATING DENTISTS

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

SECTION 6. ORAL HEALTH, TOTAL HEALTH PROGRAM

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

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

6.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

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

6.1.1 Diabetes

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

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

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

6.1.2 Pregnancy

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

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

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

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

SECTION 7. RESERVED FOR FUTURE USE

SECTION 8. EXCLUSIONS

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

Anesthesia or Sedation

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

Anesthetics, Analgesics, Hypnosis, and Medications

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

Benefits Not Stated

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

Claims Not Submitted Timely

Claims submitted more than 12 months after the date of service are not covered, except as stated in section 10.1.

Congenital or Developmental Malformations

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

Cosmetic

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

Experimental Procedures

Experimental procedures or supplies are excluded.

Facility Fees

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

Gnathologic Recordings

Gnathologic recordings or similar procedures are excluded.

Instructions or Training

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

Localized Delivery of Antimicrobial Agents

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

Missed Appointments

Charges for missed or broken appointments are excluded.

Orthodontia

Orthodontic services (treatment of malalignment of teeth and/or jaws) are excluded.

Periodontal Charting

A separate charge for periodontal charting is not covered.

Precision Attachments**Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth**

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

Services on Tongue, Lip, or Cheek

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

Services Otherwise Available

This exclusion includes:

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

Services Provided By a Relative

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

Service, War or Insurrection, Riot or Rebellion

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

Taxes**Third Party Liability Claims**

Services and supplies for treatment of illness or injury for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party.

This includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. (See section 10.3.2).

TMJ

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

Treatment After Coverage Terminates

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

Treatment Before Coverage Begins

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

Treatment Not Dentally Necessary

The Plan does not cover:

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

SECTION 9. ELIGIBILITY AND ENROLLMENT

Note: The date a person becomes eligible may be different than the date coverage begins.

9.1 SUBSCRIBERS

Employees are eligible for coverage the first day of the month following 30 days of employment with the Group. Employment in a temporary or job sharing position will count towards meeting the 30-day period, provided there is no break in service.

A person is eligible as long as:

- a. Is a regular employee of the Group; and
- b. Is and continue to be actively employed; or
- c. Is an Elected Official of the Group.

Active Employment and Actively Employed means working 20 hours or more a week at the assigned job.

NOTE: If a person is employed for a qualifying job sharing position, he or she is eligible for benefits, the required contribution is paid. If coverage is waived during the initial 30-day enrollment period, the employee may apply for coverage at any subsequent annual open enrollment period.

A retired employee is eligible if he or she is under age 65 and is a former officer or employee of a local government who is retired for services or disability and who has received or is receiving retirement benefits under the Public Employee's Retirement System or other retirement system or plan applicable to officers and employees of the local government.

9.2 WHEN COVERAGE BEGINS

For active employees coverage begins on the first day of the policy month which coincides with or follows the day they become eligible.

For retired employees coverage begins on the day they become eligible.

9.3 WHEN COVERAGE ENDS

A member's coverage will end at midnight on the earliest of:

- a. The last day of the policy month in which the policy ends;
- b. The last day of the policy month in which any premium is due and unpaid;
- c. The last day of the policy month in which a member enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
- d. The last day of the policy month in which a member is no longer eligible under the policy.

If a person is eligible because of employment, he or she will no longer be eligible when:

- a. The member resigns or retires;
- b. The member goes on leave of absence without pay (unless on an authorized FMLA Leave);
- c. The member is dismissed or laid off;
- d. The member is no longer in an eligible class; or
- e. The member does not satisfy: (1) the requirements for hours worked, or (2) any other eligibility condition in the policy.

9.3.1 If a Member Returns From Leave of Absence Without Pay

If a member returns to work within 90 days from a leave of absence without pay, coverage will be reinstated as of the date the member returns to work, provided he or she is compensated for 80 or more hours that month. Otherwise coverage will be reinstated the first day of any subsequent month in which a member is compensated for 80 or more hours.

The 90-day period for leave of absence will begin after a member has exhausted any:

- Extended health care coverage the member may qualify for under the federal Family and Medical Leave Act; and
- Supplemental pay from the County the member may be entitled to for an accepted Workers' Compensation claim.

If the member returns to work after the 90-day period, coverage will begin as of the first day of the month after he or she has completed 30 days of active employment in a qualifying position.

9.3.2 If a Member Returns From Layoff

If a member returns from a layoff within 180 days, coverage will be reinstated as of the date he or she returns to active work.

If a member returns to work from a layoff after the 180-day period, coverage will begin as of the first day of the month after he or she has completed 30 days of active employment in a qualifying position.

9.3.3 Continuation of Coverage

If a member is a retired employee and he or she pays the required premium, coverage may be continued until the member turns 65 or becomes eligible for Medicare. The spouse of a retired employee is eligible for insurance until age 65 or eligible for Medicare. The children of a retired employee are eligible until they no longer meet the definition of an eligible dependent. If the member is an active employee, refer to Section 13.

A member should contact the Group to determine the amount of contribution, if any, is required in order to continue coverage.

9.4 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. (Information on the date coverage will end is available in section 9.4.4.) 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. A subscriber's natural or adopted child;
- b. The natural or adopted child of a subscriber's spouse or domestic partner;
- c. Children placed for adoption with a subscriber. Adoption paperwork must be provided;
- d. A newborn child of an enrolled dependent for the first 31 days of the newborn's life; and
- e. 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.

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child 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. The incapacity must have arisen before the child's 26th birthday. The subscriber must provide ODS with a written physician's statement that confirms that these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by ODS' medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis except in cases where the disability is certified to be permanent.

A child who has been legally adopted by another person (coverage ends on the date custody is assumed by the adoptive parents) is also *not* eligible.

New dependents through marriage, birth or adoption, are eligible from the date they become part of the family provided they are enrolled within 60 days. Dependents not enrolled during the initial 60-day period may join the plan at the next open enrollment period. However, if a subscriber is legally required by court order to provide dental coverage for a child, that child may be enrolled in the plan at any time.

A domestic partner is eligible if he or she meets the criteria on the Affidavit of Domestic Partnership supplied by the Group. The domestic partner and his or her dependents are eligible to enroll within 60 days of when the affidavit is signed. A complete and signed application must be submitted within 60 days of the date on the affidavit.

9.4.1 Adopted Child (as federally mandated by OBRA 93)

A minor child, under the age of 18, placed with a subscriber for the purpose of legal adoption will be covered upon placement for adoption.

Coverage for such child will not continue beyond 31 days of placement for adoption unless notification and any required premium is received before that 60th day.

The child's coverage will continue subject to any required premium until the earlier of:

- The day the child's placement for adoption is terminated prior to legal adoption; or
- The day coverage would otherwise end in accordance with the policy provision.

Definition. *Placement for adoption* means assumption and retention by a subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

This provision is in addition to any other Adopted Child provision contained in the policy.

9.4.2 When Dependents Coverage Begins

If a subscriber wants to cover his or her eligible dependents, the subscriber must make a written request for dependents coverage. If the request is made before the employee is eligible for coverage, dependents coverage will begin the same day as the employee.

If an employee does not have a dependent until after he or she is covered, written request must be made no later than 60 days from the date the dependent is acquired. Coverage for that dependent will begin on the date the dependent is acquired.

If a written request is not made to cover a dependent after the 60-day limit, that dependent can only be enrolled during the annual open enrollment period.

Exception - Newborn Children. A newborn child or a newborn child of any dependent born while a member is covered in the plan, will automatically be covered, but coverage beyond 31 days for a newborn child will be continued only if any required premium is paid.

For new dependents as a result of a domestic partnership, coverage begins the first day of the month if the affidavit is signed by the first day of the month. If the affidavit is not signed on the first day of the month, coverage begins the first day of the month following the date of the affidavit.

9.4.3 Medical Child Support Order (as federally mandated by OBRA 93)

If an eligible child is not covered because the child was not enrolled for dependents coverage, such child may be enrolled after we:

- a. Receive a final medical child support order which requires enrollment; and
- b. Determine that the order is qualified.

9.4.3.1 ODS' Procedure for Determining if a Medical Child Support Order is Qualified

When ODS receives a proposed or final medical child support order, the members will be notified of the receipt of the order, in writing, at the addresses shown in the order. ODS will then review the order to decide if it meets the definition of a "qualified medical child support order". Within 30 days after receipt of the order (or within a reasonable time thereafter), a written notice of the decision will be sent to the member. ODS will also send notices to each attorney or other representative who may be named in the order or in other correspondence filed with ODS. If ODS decides that the order is not qualified, the notice will provide the specific reasons for the decision and the opportunity to correct the order or appeal the decision by contacting ODS within 30 days. If ODS decides that the order is qualified, the notice will provide instructions for enrolling each child named in the order, and the policy provisions that apply for other eligible dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends), will also apply for each child named in the order. ODS must receive a certified copy for the entire "qualified medical child support order" before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from the subscriber's pay, the Group must receive proper authorization in the order or otherwise.

As part of the authority to interpret the policy, ODS has the discretion and final authority to decide if an order meets or does not meet the definition of a "qualified medical child support order" so as to require the enrollment of a child as an eligible dependent, and a reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse dental expenses paid by a child or the child's custodial parent or legal guardian these benefits will be paid to the child or the child's custodial parent or legal guardian.

The Group will treat each child enrolled because of a “qualified medical child support order” as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

9.4.3.2 The Definition of “Qualified Medical Child Support Order”

A “qualified medical child support order” is defined by Section 609 of ERISA. In general, a “qualified medical support order” means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- a. Either: (1) relates to dental benefits under the policy and provides for a child’s support or health benefit coverage pursuant to a state domestic relation law (including a community property law); or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- b. Creates or recognizes the existence of a child’s right to be enrolled and receive dental benefits under the policy;
- c. States the name and last known mailing address (if any) of the subscriber and each child covered by the order;
- d. Reasonably describes the type of dental coverage to be provided by the policy to each child, or the manner in which this type of coverage is to be determined;
- e. States the period to which the order applies;
- f. States each policy to which the order applies; and
- g. Does not require the policy to provide any type or form of benefit or any option not otherwise provided by the policy, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

9.4.4 When Dependents Coverage Ends

A dependent’s coverage will end at midnight on the earliest of:

- a. The last day of the policy month in which the dependent is no longer eligible;
- b. The last day of the policy month in which any dependent premium is due and unpaid;
- c. The last day of the policy month in which the policy ends;
- d. The last day of the policy month in which dependents coverage under the policy ends because of lack of participation; or
- e. The last day of the policy month in which the subscriber’s coverage ends.

A covered spouse, domestic partner and/or any covered child may also elect to continue health coverage when eligibility ends. See Section 13. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.

9.4.5 Rescission by Insurer

ODS 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 or the Group. As used herein, fraud, material misrepresentation, or concealment 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. ODS reserves the right to retain premiums paid as liquidated damages, and the Group and/or member shall be responsible for the full balance of any benefits paid. Should ODS terminate coverage under this section, ODS may, to the extent permitted by law, deny future enrollment of the members under any Oregon Dental Service policy or contract or the contract of any affiliates.

9.4.6 Other

Additional information is in Section 13.

9.5 ELIGIBILITY AUDIT

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

9.6 SPECIAL ENROLLMENT RIGHTS

9.6.1 Loss of Other Coverage

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

- a. The eligible employee or dependent was covered under a group dental plan or had dental coverage at the time coverage was previously offered;
- b. The eligible employee stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined;
- c. The eligible employee requests such enrollment not later than 31 days after the previous coverage ended (except for event iv below, which allows up to 60 days); and
- d. One of the following events has occurred:
 - i. The eligible employee's or dependent's 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. The eligible employee's or dependent's 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. reaching the lifetime maximum on all benefits;
 - G. the plan ceasing to offer coverage to a group of similarly situated persons;
 - H. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan;
 - I. termination of the benefit packet option, unless a substitute option is offered.
 - iii. The employer contributions toward the eligible employee's or dependent's 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. The eligible employee's or dependent's 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.

9.6.2 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.

The special enrollment rights as described in sections 9.6.1 and 9.6.2 apply:

- a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy;
- b. To a subscriber's dependent who loses coverage under the other plan or becomes eligible for a premium assistance subsidy;
- c. To both the eligible employee and the dependent if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy.

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

9.6.3 New Dependents

An eligible employee and spouse or domestic partner will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, the registration of a Declaration of Domestic Partnership, birth, adoption, or placement for adoption); however, other existing dependents will not.

SECTION 10. CLAIMS ADMINISTRATION AND PAYMENT

The following section explains how claims are administered.

10.1 SUBMISSION AND PAYMENT OF CLAIMS

10.1.1 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 ODS within 3 years after the date the expense was incurred.

10.1.2 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.1.

10.1.3 Claim Inquiries

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

10.2 APPEALS

10.2.1 Definitions

For purposes of this section, the following definitions apply:

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

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

- a. the specific reason or reasons for the benefit denial,
- b. reference to the specific plan provision on which the denial was based,

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

10.2.2 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.

10.2.3 The Review Process

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

Note:

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

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

10.2.4 First Level Appeals

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

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

10.2.5 Second Level Appeal

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

Investigations and responses to a second level appeal will follow the same timelines outlined in section 10.2.4. ODS will notify the member in writing of the decision, including the basis for the decision.

10.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.3.1 Coordination of Benefits (COB)

This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 11.

10.3.2 Third-Party Liability

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

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

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

11.3.2.1 Definitions:

For purposes of section 10.3.2, the following definitions apply:

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a member, regardless of the characterization of the claims or damages of the member, and regardless of the characterization of the recovery funds. (For example, a member who has received payment of dental/medical expenses from ODS may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, ODS is still entitled to recover benefits as described in section 10.3.2.)

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

Recovery Funds means any amount recovered from a third party.

11.3.2.2 Subrogation

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

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

11.3.2.3 Right of Recovery

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

- a. The member holds any rights of recovery against the third party in trust for ODS, but only for the amount of benefits ODS paid for that illness or injury.
- b. ODS is entitled to receive the amount of benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the third party. This is so regardless of whether the third party admits liability or asserts that the member is also at fault. In addition, ODS is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.
- c. If, and only if, ODS asks the member, and his or her attorney, to protect its reimbursement rights under this section, then the member may subtract from the money to be paid back to ODS, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.
- d. ODS may ask the member to sign an agreement to abide by the terms of this section. If ODS elects to proceed under this section it will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

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

11.3.2.4 Motor Vehicle Accidents

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

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

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

11.3.2.5 Additional Third Party Liability Provisions

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

- a. If a member seeks payment by ODS of any benefits for which there may be a third party claim, the member shall notify ODS of the potential third party claim. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to ODS by the member's provider.
- b. Upon request from ODS, the member shall provide all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. The member and his or her representatives shall have the obligation to notify ODS in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by ODS from the third party.
- c. In order to receive an advance payment of benefits pursuant to section 10.3.2, ODS requires that any member seeking payment of benefits by ODS, and if the member is a minor or legally incapable of contracting, then the member's parent or guardian, must fill out, sign and return to ODS a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential third-party claim. If the member has retained an attorney to represent himself or herself with respect to a third-party claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that agreement.

- d. The member shall cooperate with ODS to protect its recovery rights, and in addition, but not by way of limitation, shall:
 - i. Sign and deliver such documents as ODS reasonably requires to protect its rights;
 - ii. Provide any information to ODS relevant to the application of the provisions of section 10.3.2, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
 - iii. Take such actions as ODS may reasonably request to assist ODS in enforcing its rights to be reimbursed from third party recoveries.
- e. By accepting the payment of benefits by ODS, the member agrees that ODS has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.
- f. The member agrees that ODS may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 10.3.2.
- g. Even without the member's written authorization, ODS may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.3.2.
- h. Section 10.3.2 applies to any member for whom advance payment of benefits is made by ODS whether or not the event giving rise to the member's injuries occurred before the member became covered by ODS.
- i. If the member continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a third party, ODS will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.
- j. If the member or the member's representatives fail to do any of the foregoing acts at ODS' request, then ODS has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the member related to any sickness, illness, injury or dental/medical condition arising out of the event giving rise to, or the allegations in, the third party claim. In exercising this right, ODS may notify dental/medical providers seeking authorization or prior authorization of payment of benefits that all payments have been suspended, and may not be paid.
- k. Coordination of benefits (where the member has dental/medical coverage under more than one plan or dental/medical insurance policy) is not considered a third party claim.
- l. If any term, provision, agreement or condition of section 10.3.2 is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

SECTION 11. COORDINATION OF BENEFITS

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

11.1 DEFINITIONS

For purposes of Section 11, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

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

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

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are **not** allowable expenses:

- a. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second opinions or prior authorization of services, or because the member has a lower benefit due to not using an in-network provider;
- b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
- d. If a member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

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

A **Closed Panel Plan** is a plan that provides dental benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

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

11.2 HOW COB WORKS

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

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

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

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

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

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

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

The first of the following rules that applies will govern:

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

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

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

- d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- e. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- f. **COBRA or State Continuation Coverage.** If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of an employee, member of an organization, primary insured, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, primary insured, or retiree (non-dependent) longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits
- h. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

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

11.4 EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

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

11.5 ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

11.6 FACILITY OF PAYMENT

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

11.7 RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 12. MISCELLANEOUS PROVISIONS

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

12.1 REQUEST FOR INFORMATION

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

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

12.3 TRANSFER OF BENEFITS

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

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CONTRACT PROVISIONS

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

12.6 WARRANTIES

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

12.7 LIMITATION OF LIABILITY

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

12.8 PROVIDER REIMBURSEMENTS

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

12.9 INDEPENDENT CONTRACTOR DISCLAIMER

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

12.10 NO WAIVER

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

12.11 GROUP IS THE AGENT

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

12.12 GOVERNING LAW

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

12.13 WHERE ANY LEGAL ACTION MUST BE FILED

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

12.14 TIME LIMITS FOR FILING A LAWSUIT

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

SECTION 13. CONTINUATION OF DENTAL COVERAGE

13.1 INDIVIDUAL DENTAL EXCHANGE PROGRAM

There is an individual dental plan available to members who have been covered under an employer-sponsored dental plan for 12 continuous months prior to their termination date and loss of coverage. A member must be an Oregon resident to enroll and maintain eligibility for this coverage. The Individual Dental Exchange Program is an individual plan and the benefits are not the same as those provided under the Group's dental plan. Members may enroll in this individual plan regardless of any other continuation coverage that may be available through the Group.

Note: The following sections on continuation of coverage may apply. Members should check with the Group's benefits manager to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

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

13.2.1 Introduction

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

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

- a. ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
- b. ODS will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice, election, or other requirements outlined in the following sections; and
- c. 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 13.2 the term "domestic partner" refers only to a registered domestic partner, as defined in Section 4.

13.2.2 Eligibility Requirements for 55+ Oregon Continuation Coverage

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

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

13.2.3 Notice And Election Requirements For 55+ Oregon Continuation Coverage

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

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the 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 the surviving, legally separated or former domestic partner, that coverage can be continued, along with an election form. If the Group or its designated third party administrator fails to notify the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, within the required 14 days (or 44 days if there is no third party administrator), premiums shall be waived until the date notice is received.

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

13.2.4 Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, to the 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.

13.2.5 When 55+ Oregon Continuation Coverage Ends

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

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

13.3 COBRA CONTINUATION COVERAGE

13.3.1 Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of section 13.3, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the subscriber and the subscriber’s spouse and dependent children. The Plan Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration. Specific qualifying events are listed below.

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

- a. **Other than the exception on domestic partner coverage**, ODS will offer no greater COBRA rights than the COBRA statute requires;
- b. ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election, or other requirements outlined below; and
- c. ODS will not provide COBRA coverage if the Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the Plan Administrator otherwise fails to comply with any of the requirements outlined below; and
- d. ODS will not provide a disability extension if the Plan Administrator fails to notify ODS within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

13.3.2 Qualifying Events

- a. **Subscriber.** A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include, but is not limited to, misrepresenting immigration status to obtain employment), a reduction in hours, or, for a retired subscriber, the Group files for reorganization under Chapter 11 of the bankruptcy code.
- b. **Spouse.** The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:
 - i. The death of the subscriber;
 - ii. The termination of the subscriber’s employment (for reasons other than gross misconduct) or reduction in the subscriber’s hours of employment with the Group;
 - iii. Divorce or legal separation from the subscriber;
 - iv. The subscriber becomes entitled to Medicare; or
 - v. The retired subscriber’s former employer (i.e. the Group) files for Chapter 11 reorganization.

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

- c. **Children.** A dependent child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:
- i. The death of the subscriber;
 - ii. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group;
 - iii. Parents' divorce or legal separation;
 - iv. The subscriber becomes entitled to Medicare;
 - v. The child ceases to be a "dependent" under the Plan; or
 - vi. The retired subscriber's former employer (i.e. the Group) files for Chapter 11 reorganization.
- d. **Domestic Partners.** A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

13.3.3 Other Coverage

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

13.3.4 Notice and Election Requirements

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

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

Otherwise, members will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, 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 Plan Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental insurance coverage for all members will end.

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

13.3.5 COBRA Premiums

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

13.3.6 Length of Continuation Coverage

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

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

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

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

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.

13.3.7 Extending the Length of COBRA Coverage

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

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the subscriber's termination of employment or

reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

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

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

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 13.2).

13.3.8 Newborn or Adopted Child

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

13.3.9 Special Enrollment and Open Enrollment

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

13.3.10 When Continuation Coverage Ends

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

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

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

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

13.3.11 The American Recovery and Reinvestment Act of 2009 as amended

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

13.4 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active 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 and the pre-existing condition limitation, if any, will be credited as if the subscriber had been continuously covered under the Plan from the original effective date. (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).

13.5 FAMILY AND MEDICAL LEAVE

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

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

13.6 LEAVE OF ABSENCE

If granted a non-FMLA leave of absence by the Group, a subscriber may continue coverage for up to 3 months. Premiums must be paid through the Group in order to maintain coverage during a 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, including disability and maternity.

13.7 STRIKE OR LOCKOUT

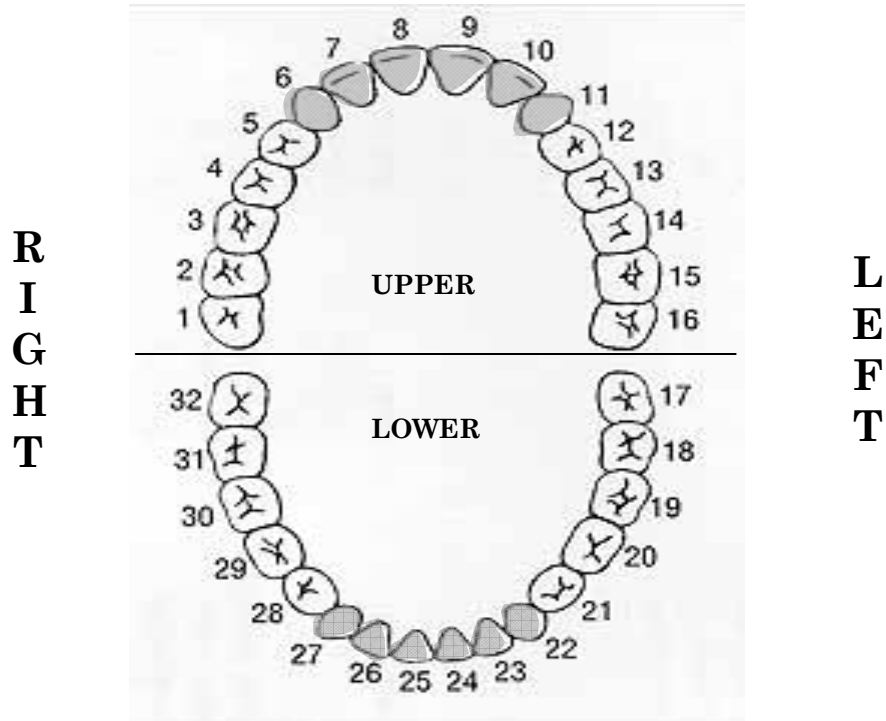
If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union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

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

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

SECTION 14. EXHIBITS

14.1 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)

14.2 EXAMPLE OF HOW THE PLAN PAYS

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

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

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

Total Out of Pocket Expense

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

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

Total Out of Pocket Expens

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



Insurance products provided by Oregon Dental Service

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Portland, OR 97204

Member Inquiries

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Toll-Free 888-217-2365

Relay Service 711 (for the hearing and speech impaired)

En Español 503-265-2963

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