DELTA DENTAL®

2023
Oregon Group Dental Plan

Multnomah County
Delta Dental PPO 50 Plan
Classes: 0001, 0002, 0003, 0004, 0005, 0006, 0007, 0008, 0009, 0010, 0011, 0013 and 0014

Effective date: January 1, 2023
Group number: 10001684

Multnomah County

Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims

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SECTION 1. WELCOME

This handbook will give you important information about the Plan's benefits, limitations and procedures. It does not waive any of the conditions of the Plan as set out in the Plan Document. The Plan is self-funded and the Group has contracted with Delta Dental Plan of Oregon to provide claims and other administrative services.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.deltadentalor.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

This handbook may be changed or replaced at any time without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Delta Dental determines there is a legitimate business purpose for doing so.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to your **Member Dashboard**)
www.DeltaDentalOR.com
Includes many helpful features, such as Find Care (use to find an in-network dentist)

Dental Customer Service Department
Toll-free 888-447-8194
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

After enrolling, you will receive ID (identification) cards that will include your group and identification numbers. Show your card each time you receive services. You may go to your Member Dashboard or contact Customer Service to replace a lost ID card.

2.3 NETWORK

See Network Information (section 4.1) for details about how networks work.

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in section 16 and section 6.

SECTION 3. GENERAL PLAN INFORMATION

Funding Medium and Type of Plan Administration: The Plan is self-funded and the Group has contracted with Delta Dental to provide claims and other administrative services.

The Plan is funded by the Group and/or Subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion you pay toward the total contribution is determined by the Group and your bargaining unit.

SECTION 4. USING THE PLAN

For questions about the Plan, you should contact Customer Service.

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

At a first appointment, you should tell the dentist that you have dental benefits administered by Delta Dental. You will need to provide your identification number and Delta Dental group number to the dentist. These numbers are located on your ID card.

4.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. This plan offers the same annual maximum plan payment limit, deductibles and coinsurance whether you see an in-network dentist (Delta Dental PPO or Delta Dental Premier) or an out-of-network dentist.

If you choose an in-network dentist (available on your Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. For members outside Oregon, Delta Dental national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

If you need dental care, you may go to any dental office. However, **there are differences in reimbursement by the Plan for Delta Dental PPO dentists, Delta Dental Premier dentists and out-of-network dentists or dental care providers**. While you may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

4.1.1 In-Network Delta Dental Dentists

When using a Delta Dental PPO dentist or Delta Dental Premier dentist, the dentist may not charge you the difference between the plan allowance and the billed amount for covered services.

Payment to a Delta Dental PPO dentist will be the lesser of the PPO fee schedule and the dentist's actual billed fees.

Payment to a Delta Dental Premier dentist will be the lesser of the dentist's filed or contracted fee with Delta Dental or fees actually charged.

4.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist or dental care provider is paid at the applicable coinsurance and limited to the maximum plan allowance for an out-of-network dentist or dental care provider. The allowable fee for providers in states other than Oregon will be that state's Delta Affiliate's non-participation dentist allowance. You may have to pay the difference between the payable maximum allowed amount and the billed charge.

4.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current benefits and returned to the dentist. You and your dentist should review the information before beginning treatment. The Group encourages you to take advantage of this opportunity to identify what level of coverage will be available for proposed care.

SECTION 5. DEFINITIONS

Alveolar Structures are the upper and lower jaw bones.

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 6).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 6).

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 your tooth that is made at a laboratory or dental office and cemented into the tooth.

Coinsurance is a percentage of covered expenses that you pay.

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

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

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

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

Declaration of Marriage or Domestic Partnership is a signed document that attests that you and one other eligible person meet the criteria in the declaration to be a spouse or not state registered domestic partner. Document is required by the Group from every employee who seeks to enroll a spouse or domestic partner for dental plan coverage.

Deductible is the amount of covered expenses that you pay before benefits are payable by the Plan.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Where this book refers to "we", "us", or "our" it is referring to Delta Dental or its employees.

Delta Dental is the claims administrator of the Plan. A reference to Delta Dental as paying claims or issuing benefits means that Delta Dental processes the claim and the Group reimburses Delta Dental for any benefit issued.

Dental Consultant means a dentist employed by Delta Dental to review treatment plans for predetermination, review dental treatment for dental necessity, evaluate codes for determining accepted fee, and to provide assistance and direction with dental claims.

Dentally Necessary means services that, in the judgment of Delta Dental:

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

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 licensed dentist operating within the scope of their license as required under law within the state of practice.

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

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

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

a. **State Registered Domestic Partner** means a person joined with you in a partnership that has been registered in Oregon under the Oregon Domestic Partner Registry according to the Oregon Family Fairness Act.
b. **Not State Registered Domestic Partner** means a person who is not married or registered in Oregon under the Oregon Family Fairness Act, and has entered into a partnership with you that meets the criteria in the Group's declaration of domestic partnership.

Effective Date means the date a member's coverage becomes effective under the terms of this Plan.

Eligible Employee refers to any person who:

a. is a permanent employee of the Group
b. is not a seasonal, substitute, or an agent, consultant or independent contractor

c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Group on a regularly scheduled basis at least 20 hours per week

Emergency Services means services for a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. Includes services to treat the following conditions: acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

Enrollment Date means, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

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

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

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

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

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

In-Network Delta Dental PPO Dentist means a licensed dentist who contracts in the preferred provider network (PPO) to provide dental care to members.

In-Network Delta Dental Premier Dentist means a licensed dentist who contracts in the Premier network to provide dental care to members.

Limited Exam is an examination of a specific oral health problem or complaint.

Maximum Dental Payment Limit means the amount payable by the Plan for covered Class I, II and III services received each year, or portion thereof, for each member.

Maximum Orthodontic Payment Limit means the amount payable by the Plan for covered orthodontic services per lifetime for each member eligible for the benefit (within the age constraints).

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers:

a. For a Delta Dental PPO dentist, the maximum amount is based on the PPO allowable fee. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental's dental consultant who determines a comparable code

to the one billed. Delta Dental PPO dentists will not require payment from the member for billed fees in excess of the maximum plan allowance.

b. For a Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with Delta Dental. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental's dental consultant who determines a comparable code to the one billed. Premier dentists will not require payment from the member for billed fees in excess of the maximum plan allowance.
c. For an out-of-network dentist, the maximum amount is based on a per service average allowance of the Delta Dental Premier dentists' filed or contracted fees. *When using an out-of-network dentist or dental care provider, any amount above the maximum plan allowance is the member's responsibility.*

Member is subscriber or dependent of a subscriber who has enrolled for coverage under the terms of the Plan. Where this book refers to "you" or "your" it is referring to a member.

Out-of-Network Dentist or Dental Provider means a licensed dental provider who has not contracted as a Delta Dental PPO dentist or a Delta Dental Premier dentist.

Palliative Treatment is treatment performed only to control pain, swelling, or bleeding in or around the teeth and gums. Palliative Treatment does not include follow-up care or definitive Restorations such as, but not limited to, crowns, extractions, or root canal treatment.

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

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

The **Plan** is the dental benefit plan sponsored and funded by the Group. Delta Dental is contracted to provide claims and other administrative services.

Plan Sponsor is the Group.

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

Posterior refers to teeth located toward the back of the mouth (tooth chart in section 6).

PPO Fee Schedule is the amount negotiated between Delta Dental and a participating Delta Dental PPO dentist.

Prophylaxis is cleaning and polishing of all teeth.

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

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

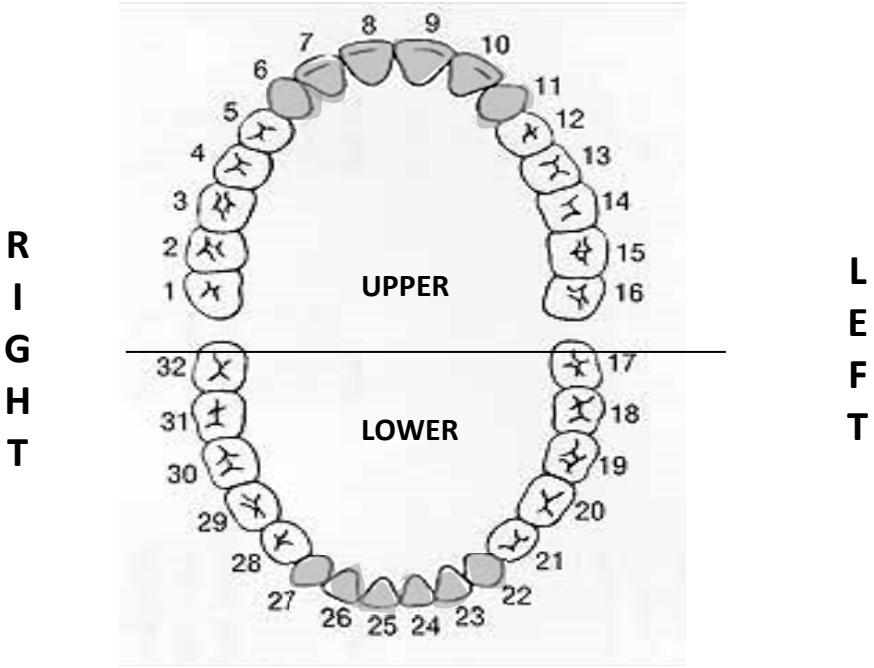
Retainer is a tooth used to support a prosthetic device (bridges, partial dentures or overdentures). Also see **Implant Abutment.**

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

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

SECTION 6. TOOTH CHART

THE PERMANENT ARCH



Note: The shaded teeth in the chart above are the Anterior (front) teeth. The non-shaded teeth are the Posterior (back) teeth.

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)

SECTION 7. BENEFITS AND LIMITATIONS

Note: Benefits are paid based on a PLAN YEAR – January through December.

The Plan covers the services listed when performed by a dentist or dental care provider (licensed denturist or licensed hygienist), and only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. Delta Dental's dental consultants and dental director determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance. Benefits will never be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered by your medical plan will not be covered on this Plan except when related to an accident.

Covered dental services are outlined in 3 categories or classes: Class 1 – Preventative, Class II – Restorative, Class III – Major Care. The reimbursement rate differs for each class.

Limitations may apply to these services, and are noted below. See section 11 for exclusions.

Covered services, when generally accepted dental practices and standards determine they can be safely and effectively provided using teledentistry (audio, video or both), are covered when provided by a provider using such telephone or internet conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information.

All annual or per year benefits or cost sharing accrue based on a plan year (January 1st through December 31st) or portion thereof. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

Annual Deductible: $50
Per member (not to exceed $150 per family) per year, or portion thereof
Deductible applies to covered Class II and Class III services

Annual Maximum Plan Payment Limit: $2,000
Per member per year, or portion thereof.
All covered services (Class I, II, III) except orthodontia apply to the annual maximum plan payment limit. See separate Orthodontia benefit information in section 10. Members are responsible for expenses that exceed the annual maximum plan payment limit and maximum orthodontic payment limit.

7.1 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly dentally sound treatment. You will be responsible for the remainder of the dentist's fee. Using the pre-determination process can help a member avoid this situation.

7.2 CLASS I: COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE

7.2.1 Diagnostic

a. Diagnostic Services:

i. Examination
ii. Consultations for covered dental procedures
iii. Intra-oral x-rays to assist in determining required dental treatment.

b. Diagnostic Limitations:

i. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
ii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, bitewing and Cone Beam x-rays

7.2.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings) including cleaning of implants
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Interim caries arresting medicament application
v. Sealants
vi. Space maintainers

b. Preventive Limitations:

i. Coverage for periodontal maintenance (procedure code D4910) is limited to once in any 3-month period. This service is in lieu of a regular prophylaxis (section 7.2.2.a.i).
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered for members under age 23
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. 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. Sealants are not covered when applied to primary (baby) teeth.
vi. Space maintainers are a benefit for one space per quadrant for members under age 14. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 and over are not covered.

7.3 CLASS II:
COVERED SERVICES PAID AT 80% OF THE MAXIMUM PLAN ALLOWANCE

7.3.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings for the treatment of decay
ii. Stainless steel crowns

b. Restorative Limitations:

i. Restorations are not covered within 2 months of interim caries arresting medicament application.
ii. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided. **The member is responsible for paying the difference.**
iii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains.
v. Replacement of a stainless steel crown by the same dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.
vi. Additional limitations when teeth are restored with crowns or cast restorations are in section 7.4.1.

7.3.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical)
ii. Other minor surgical procedures

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
ii. Surgery on larger lesions (generally 1.25 cm or larger) or malignant lesions is not considered minor surgery.
iii. A separate charge for post-operative care done within 30 days following an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
iv. Osseous surgery (including flap entry and closure) is covered once in a 3-year period per quadrant with a maximum of 2 quadrants per visit.

7.3.3 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. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. A separate charge for pulp capping is not covered. Pulp capping is considered to be included in the fee for the final restoration.
iv. Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.
v. A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.

7.3.4 Periodontic

a. Periodontic Services:

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants. For benefits that renew based on a time period, the calculation of the benefit renewal period begins with the last date of treatment. Services rendered prior to the benefit renewal date will not be eligible for coverage.

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
ii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
iii. Bone replacement grafts are covered once per quadrant in a 3-year period.
iv. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
v. Full mouth debridement is limited to once in a 2-year period and, if the member is age 19 or older, only if there has been no cleaning (prophylaxis, periodontal maintenance) within a 2-year period.

c. Repair:

i. Repair of existing dentures and bridges. Repair within 6 months after the initial placement is not covered. Subsequent repairs are covered once per denture in any 12-month period. Contact Delta Dental prior to treatment for verification of coverage for proposed treatment.

d. Palliative Treatment:

i. Emergency services primarily for relief, not cure.

7.3.5 Anesthesia Services

a. General anesthesia or IV sedation

Covered only:

i. In conjunction with covered surgical procedures performed in a dental office
ii. When necessary due to concurrent medical conditions

7.3.6 Miscellaneous

a. Miscellaneous Services:

i. Nitrous oxide

7.4 CLASS III:
COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

For benefits that renew based on a time period, the calculation of the benefit renewal period begins with the last date of treatment. Services rendered prior to the benefit renewal date will not be eligible for coverage.

7.4.1 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. Crown buildups are considered to be part of the service and included in the crown restoration cost. A separate fee for a buildup will be considered for benefits only if the buildup is necessary for tooth retention and covered as a Class II service (see 7.3.1.b.iv)

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 by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

iv. Restorations are not covered within 2 months of interim caries arresting medicament application.

v. Re-cement or re-bond of a crown, inlay, or veneer, by the same dentist, is limited to once per lifetime.

7.4.2 Prosthodontic

a. Prosthodontic Services:

i. Bridges

ii. Partial and complete dentures

iii. Denture relines

iv. Implants and implant maintenance

v. Surgical stent in conjunction with a covered surgical procedure

vi. Athletic mouthguard

vii. Nightguards for treatment of temporomandibular joint syndrome (TMJ) or tooth grinding (bruxing)

b. Prosthodontic Limitations:

i. A bridge or a 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 being decayed or broken.

iv. Denture adjustments and relines*:* A separate, additional charge for denture adjustments 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 3-year period.

vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:

   A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space 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; 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 1 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.**

ix. Prosthodontics are not covered within 2 months of interim caries arresting medicament application.

x. Replacement of dentures or partial dentures will not be covered if the replacement is due to loss, theft, or breakage unless it has been 5 years since the original/initial/last purchase

xi. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.
xii. Nightguards: one nightguard is covered every 3 calendar years. Lost or broken nightguards will not be covered unless it has been 3 years since the original/initial/last purchase. Nightguard repairs or relines done within 6 months of placement of nightguard by same provider are not covered. Adjustments done within 6 months of placement of nightguard by same provider and within 12 months by any provider are not covered. Repair or reline and adjustment of occlusal guard is covered once every 12-month period.
xiii. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

SECTION 8. ORAL HEALTH, TOTAL HEALTH BENEFITS

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy. Studies have shown a relationship between periodontal disease, bacteria in the mouth, and various health problems including pre-term, low birth weight babies and diabetes.

8.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

The Plan offers a Delta Dental program that provides additional cleanings (prophylaxis or periodontal maintenance) for Delta Dental members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 7.

8.1.1 Diabetes

If you have diabetes, elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

8.1.2 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. Data also suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

You should talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy.

8.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on your Member Dashboard. Members with diabetes must include proof of diagnosis.

SECTION 9. HEALTH THROUGH ORAL WELLNESS PROGRAM

The Plan offers enhanced benefits through Delta Dental's Health through Oral Wellness program (see section 9.3) to members at high risk of tooth decay, gum disease and oral cancer as determined by a clinical risk assessment administered by a dentist registered with the program.

Dentists registered with the Health through Oral Wellness program are licensed dentists who have agreed to perform a clinical risk assessment as part of a member visit.

9.1 How to Find a Dentist Registered with the Health through Oral Wellness Program

To find a dentist registered with the Health through Oral Wellness program in Oregon, you can log in to your Member Dashboard account at www.DeltaDentalOR.com and select Find Care.

a. Choose the "Dental" option under the Type of search drop down menu
b. Enter your location and Search

This will bring up a list of local dental providers. Dentists registered with the Health through Oral Wellness program will have a green ribbon (the Health through Oral Wellness badge icon) next to their contact information.

You may also contact Customer Service for assistance finding a dentist registered with the program.

9.2 Clinical Risk Assessment

Clinical risk assessments objectively determine your risk of tooth decay, gum disease or oral cancer. If you are determined to be high risk in one of these three categories you will be informed of your enhanced benefits by the registered dentist. You may be eligible for enhanced benefits based on more than one risk category. A clinical risk assessment that covers all three risk categories is called a comprehensive risk assessment.

9.2.1 Tooth Decay Risk Assessment

If you are eligible for enhanced benefits based on your risk of tooth decay, you must take a tooth decay risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain your eligibility. Eligibility for enhanced benefits will continue regardless of your risk score for tooth decay at a subsequent risk assessment provided there is no lapse in eligibility.

9.2.2 Gum Disease Risk Assessment

If you are eligible for enhanced benefits based on your risk of gum disease, you must take a gum disease risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain your eligibility. Eligibility for enhanced benefits will continue regardless of your risk score for gum disease at a subsequent risk assessment provided there is no lapse in eligibility.

9.2.3 Oral Cancer Risk Assessment

If you are eligible for enhanced benefits based on your risk of oral cancer, you must take an oral cancer risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain your eligibility. Your oral cancer risk score may affect your eligibility for enhanced benefits; see section 9.4 for more information.

9.3 ENHANCED BENEFITS

9.3.1 Tooth Decay and Gum Disease Enhanced Benefits

If you qualify for enhanced benefits under the Health through Oral Wellness program based on a high risk of tooth decay or gum disease, you are eligible for:

a. Prophylaxis (cleaning) or periodontal maintenance,
b. Fluoride varnish or topical fluoride,
c. Sealants on the unrestored occlusal surfaces of permanent molars once per tooth every 3 years,
d. Oral hygiene instruction or nutritional counseling once in any 12-month period, and
e. Drugs or medicaments dispensed in the office for home use once in any 6-month period.

9.3.2 Oral Cancer Enhanced Benefits

If you qualify for enhanced benefits under the Health through Oral Wellness program based on a high risk of oral cancer, you are eligible for tobacco cessation counseling once in a 12-month period.

9.3.3 Limitations

All enhanced benefits are subject to the Plan's annual maximum plan payment limit, deductible, coinsurance and other plan limitations.

Oral hygiene instruction, nutritional counseling, and tobacco cessation counseling, not otherwise covered under the Plan, are covered as Class I benefits.

Drugs and medicaments, not otherwise covered under the plan, are covered as a Class II benefit.

With the exception of tobacco cessation counseling, enhanced benefits may not be combined with the additional benefits available through the Oral Health Total Health program described in section 8.

9.4 WHEN ENHANCED BENEFITS END

If you do not receive continued clinical risk assessments as required in section 9.2, you will lose your eligibility for enhanced benefits. Standard plan benefits, see section 7, will resume 14 months from the last clinical risk assessment.

Your tobacco cessation counseling enhanced benefit will end if a subsequent clinical risk assessment determines that you are no longer at high risk for oral cancer.

SECTION 10. ORTHODONTIC BENEFIT

10.1 ORTHODONTIC BENEFIT

Maximum Orthodontic Payment Limit: $3,000
Per each member per lifetime
Including $35 for diagnosis once in any five-year period

The Plan will cover 50% of the maximum plan allowance for necessary orthodontic treatment up to a lifetime maximum of $3,000 for a member. Maximum plan allowance are charges we determine fall within a range of those most frequently made for services and supplies in its service area by those who supply them.

Covered services are the installation of orthodontic appliances, including placement of a device to facilitate eruption of an impacted tooth, and treatment to reduce or eliminate malocclusion. The Plan will also pay $35 for diagnosis, including models and photographs, once in any five-year period. This $35 benefit is included in the lifetime maximum of $3,000.

Before benefits are payable, we must approve a treatment plan.

Treatment Plan: This is a report written by your orthodontist listing proposed services and fees. This report must include the total orthodontic charge, the initial banding fee and the estimated length of time for required treatment. It must be based on an examination which takes place while you are covered by the Plan, and it must show a diagnosis indicating an abnormal occlusion which can be corrected by orthodontic care.

In order for the Plan to pay for covered services, especially in cases where treatment is under way when coverage begins or ends, only orthodontic treatment performed while you are covered under the Plan is eligible for consideration and treatment period cannot exceed the original length of time prescribed in the original treatment plan.

10.2 LIMITATIONS

The Plan's obligation to make monthly or other periodic payments for treatment will cease upon termination of treatment for any reason prior to completion.

The Plan's obligation to make monthly or other periodic payments for treatment shall cease on termination of your coverage under the Plan.

If treatment began before you were eligible for coverage under the Plan, the Plan will base its obligation on the balance of the dentist's normal payment pattern, calculated based on your coverage effective date with a Delta Dental plan. The maximum orthodontic payment limit will apply to this amount.

Self-administered orthodontics and repair or replacement of an appliance furnished under the Plan are not covered.

SECTION 11. EXCLUSIONS

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

Analgesics
Substances used for pain relief

Anesthesia or Sedation
Local anesthetics, general anesthesia and/or IV sedation except as stated in section 7.3.5

Behavior Management
Additional services, time or assistance to control the actions of a member

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

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service, except as stated in section 14.1.

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

Coping
A thin covering over the visible part of a tooth, usually without anatomic conformity

Cosmetic Services
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

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

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

Gnathologic Recordings
Services to observe the relationship of opposing teeth, including occlusion analysis

Hypnosis

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

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

Instructions or Training
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction except as allowed under Health Through Oral Wellness as seen in section 9

Localized Delivery of Antimicrobial Agents
Time released antibiotics to remove bacteria from below the gumline

Maxillofacial Prosthetics
Except for surgical stents as stated in section 7.4.2

Medications
Including any other prescribed drugs, except as allowed under Health Through Oral Wellness as seen in section 9. (Prescriptions for pain or infection may be eligible for coverage under the your prescription medication benefit plan and must be purchased through a WellDyneRx participating pharmacy if you are enrolled in a Moda Health medical plan or Kaiser if enrolled in a Kaiser medical plan.)

Missed Appointment Charges

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

Over the Counter
Including over the counter occlusal guards and athletic mouthguards

Periodontal Charting
Measuring and recording the space between a tooth and the gum tissue

Precision Attachments
Devices to stabilize or retain a prosthesis when seated in the mouth

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except nightguards or athletic mouthguards as provided in section 7.4.2. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

Self-Treatment
Services you provide to yourself

Service Related Conditions
Treatment of any condition caused by or arising out of your service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by your military or veterans coverage.

Services on Tongue, Lip, or Cheek
Such services may be covered by the your medical plan.

Services Otherwise Available
Including those services or supplies:

a. compensable under workers' compensation or employer's liability laws
b. provided by any city, county, state or federal law, except for Medicaid coverage
c. provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Splints and Other Appliances
Including those used to increase vertical dimensions, restore bite, or correct habits such as tongue thrusting or teeth grinding (except nightguards).

Taxes

Teledentistry Fees
A separate charge for teledentistry is not covered. Teledentistry is covered in the normal charge for the service.

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 14.3.2)

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ) (except for nightguards in section 7.4.2).

Treatment After Coverage Ends
Except for cast restorations and prosthodontic services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after your eligibility ends. This exception is not applicable if the Group transfers its plan to another administrator.

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

Treatment of Closed Fractures

SECTION 12. ELIGIBILITY

The date you become eligible may be different than the date coverage begins (see section 13.1).

The Group's eligibility provisions provide broader dependent eligibility rules for coverage than IRS regulations which govern the Plan. If you elect to enroll a family member who meets the Group's definition of a dependent but DOES NOT meet the IRS definition of a spouse, qualified child, or qualified relative, the payroll deduction for that enrolled dependent's coverage will be taken as a post-tax deduction and you will pay tax on the value of the coverage for that dependent.

12.1 SUBSCRIBER

12.1.1 Non-Represented Employees

You are eligible to enroll in the Plan if you work at least 20 hours a week on a regular basis in a temporary (with benefits) or permanent exempt position for the Group. You may be eligible to remain covered while on an approved leave of absence under state or federal family and medical leave laws.

12.1.2 Represented Employees

You are eligible to enroll in the Plan if you are covered by any of the labor contracts, and work at least 20 hours a week on a regular basis in a permanent position for the Group. You may be eligible to remain covered while on an approved leave of absence under state or federal family and medical leave laws.

12.1.3 Retirees

You may be eligible to continue dental coverage. See the labor agreement or Personnel Rule (for non-represented employee benefits) for Retiree requirements and any premium payment obligations. You may be allowed to waive retiree coverage and sign up at a later date if covered continuously by another group dental plan.

12.2 DEPENDENTS OF SUBSCRIBERS

Your legal spouse or domestic partner (as defined in the labor agreement between the Union and the County or Personnel Rule for non-represented employee benefits) is eligible for coverage. Your children and children of your spouse or domestic partner are eligible for coverage until their 26th birthday if they meet the eligibility requirements. A child is also eligible if a court or administrative order requires you to provide health coverage. **Eligible dependents must be properly enrolled in order to obtain coverage**. If you are actively employed, you must accurately report the relationship of all children so it can be determined whether the enrolled children meet IRS criteria as a "child under the age of 27", a qualified child or a qualified relative. Enrolled children who do not meet these criteria may be eligible for coverage but create a tax event for you.

You are responsible for notifying the Group in the event an enrolled dependent ceases to be eligible. Failure to make a timely report of a dependent's loss of eligibility can cause a forfeiture of that dependent's COBRA continuation of coverage rights.

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

a. Children who are under age 26 and are your biological child, step-child, adopted child, child in your custody pending adoption, a child for whom you are required by court order to provide coverage, a child for whom you are a court appointed legal guardian (up to the age of majority, or the age specified by the court), or a biological/adopted child of the domestic partner.

12.2.1 Extension of Coverage for Children with Disability

If you have an enrolled dependent child who would lose eligibility for coverage based on age and is physically or mentally incapable of self-support due to a condition, the child may be eligible for coverage beyond these age limits under this provision. To remain eligible, the following conditions must be satisfied:

a. The child must have been enrolled in the Plan and have had continuous dental coverage prior to the age triggered loss of eligibility, and
b. The child must be unmarried, not registered as anyone's domestic partner under the Oregon Family Fairness Act, and principally dependent on you for support, and
c. The disability must have arisen before the age triggered loss of eligibility, and
d. You must provide us with a written physician's statement confirming the child has a condition rendering the child physically or mentally incapable of self-support and that the condition existed continuously prior to the loss of eligibility. Social Security Disability status does not guarantee coverage under this provision.

Documentation of the child's medical condition must be reviewed and approved by a Delta Dental medical consultant in order for the child to remain covered. **This initial review must be completed in advance of the child losing eligibility for coverage**.

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

12.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

12.4 NEW DEPENDENTS OF SUBSCRIBERS

Generally you have 60 days from the date a new dependent is obtained to complete and submit an enrollment request for that dependent. The following is an explanation of when the new dependent's coverage would begin – if the enrollment is submitted within that enrollment period. Should you fail to submit an enrollment request during the enrollment period, you may have to wait until the next annual open enrollment in order to add the new dependent to coverage.

12.4.1 Marriage

If you marry while covered under the Plan, the spouse and dependent children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically, and submitted to the Group during the 60 days immediately following the marriage date. If submitted during the 60 day enrollment period, coverage begins the first of the month following or coinciding with the date the Group receives the completed enrollment documentation.

12.4.2 Domestic Partnership – State Registered

State of Oregon Domestic Partner Registry: If you establish a domestic partnership and obtain a certificate from the State of Oregon's Domestic Partner Registry, the domestic partner and dependent children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically and submitted during the 60 days immediately following the domestic partner registry. If submitted during the 60 day enrollment period, coverage begins the first of the month following or coinciding with the date the Group receives completed enrollment documentation.

12.4.3 Domestic Partnership – Multnomah County Registered

Multnomah County Domestic Partner Registry: If you establish a domestic partnership and obtain a certificate from the Multnomah County Domestic Partner Registry, the domestic partner and dependent children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically and submitted during the 60 days immediately following the domestic partner registry. If submitted during the 60 day enrollment period, coverage begins the first of the month following or coinciding with the date the Group receives completed enrollment documentation.

12.4.4 Domestic Partnership – Shared Residency

Based on Shared Residence: If you establish a domestic partnership and do not obtain a certificate from the Multnomah County Domestic Partner Registry or the State of Oregon's Domestic Partner Registry, the domestic partner and dependent children become eligible for enrollment under the Plan six months following the date the partnership (and shared residency) commences. However, the six month shared residence period cannot include any period during which either partner was either legally married to another person, or involved in a state registered domestic partnership. In those instances, the six month residency period does not begin until the divorce or dissolution of domestic partnership is finalized. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed and signed electronically during the 60 days immediately following the end of the six month residency requirement and submitted to the Group during that period. If submitted during the 60 day enrollment period, coverage begins the first of the month following or coinciding with the date the Group receives completed enrollment documentation.

12.4.5 Newborn Child

Your newborn child is automatically eligible for coverage under the Plan for 31 days following birth. During this period you must submit enrollment. Enrollment must be submitted to the Group within 60 days of the child's birth. Coverage for the child will terminate after 31 days unless you have submitted a completed enrollment. If the enrollment is submitted after coverage is terminated but within 60 days of birth, coverage will be reinstated retroactively with no break in coverage.

12.4.6 Newborn Child of An Enrolled Child

A newborn of your enrolled child is automatically eligible for coverage under the Plan for 31 days following birth. You should contact the Group within 60 days to request the 31-day enrollment of the newborn.

In certain situations, the newborn may also be eligible for coverage beyond the 31-day period. In addition to the requirements for all child dependents under the Plan, the following conditions must also be satisfied if the newborn is to remain enrolled in the Plan:

a. At the time of birth, the grandchild's birth parent must be unmarried, under age 26, and enrolled as a dependent under the Plan, and
b. You must submit enrollment for the grandchild within 60 days of birth, and
c. The grandchild's birth parent must remain unmarried, under age 26 and otherwise eligible and enrolled for coverage as a dependent under the Plan, and
d. Both the grandchild and birth parent reside in your home.

A grandchild's continued eligibility for coverage depends on the birth parent. After initial enrollment, a grandchild is only eligible for coverage while all of the conditions listed above remain satisfied. At the time the child's birth parent no longer meets the requirements listed above, the grandchild's eligibility will terminate and coverage will end– *even if the birth parent remains covered*. Should this occur, you would need to obtain legal guardianship of the grandchild in order to retain coverage as a dependent.

Limitations

If you do not submit enrollment for a newborn grandchild within 60 days of birth, the child will lose eligibility for coverage. You would need to obtain legal guardianship of the grandchild in order to enroll the grandchild as a dependent at a later date.

Similarly, if you decide to terminate coverage of a grandchild, you would need to obtain legal guardianship of the grandchild in order to re-enroll the grandchild as a dependent at a later date.

12.4.7 Adopted Child

Adopted children are eligible from the date of the adoption decree. A child who is placed with you pending the completion of adoption proceedings will become eligible on the date of placement with you. An adopted child or child placed pending adoption is eligible for coverage for 31 days from the date of adoption or date of placement. To begin coverage, the Group must be notified of the adoption and provided with the placement or adoption documentation.

You must enroll to continue coverage beyond the first 31 days. The enrollment must be submitted to the Group within 60 days of the child's adoption or placement for adoption.

Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

12.4.8 Tax Impact of Dependent Health Benefits

The Group's eligibility rules identifying the dependents who are eligible for enrollment under the Plan are broader than the Internal Revenue Code (IRC) rules identifying dependents who are eligible for tax-free health plan coverage. Passage of the Affordable Care Act (ACA) in 2010 changed the IRC definition of a child specifically for purposes of health plan coverage. The following persons are able to receive tax-favored health coverage within the meaning of the IRC if enrolled by you, if you are an active employee (taxpayer):

a. "Children under age 27". "Children under age 27" are:
    i. the taxpayer's biological, adopted, foster or step-children; and
    ii. who as of the end of the taxable year have not attained age 27.
b. "Qualifying Children". Qualifying children are the taxpayer's children by birth, adoption, stepchildren, or foster children who:
    i. are under age 19, or under age 24 in the case of a full-time student, on the last day of the calendar year, or any age if totally disabled; and
    ii. do not provide over one-half of their own support; and
    iii. have the same principal place of residence as the taxpayer for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
c. "Qualifying Relatives". Qualifying relatives are:
    i. the taxpayer's children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from the taxpayer and who do not meet the above "Qualifying Child" requirements with respect to any other person;
    ii. or, persons who:
        A. share the taxpayer's residence as a member of the household;
        B. who receive over half of their support from the taxpayer; and
        C. who do not meet the above "qualifying child" requirements with respect to any other person.

        Note regarding (C) above: a taxpayer can treat another person's qualifying child as a "Qualifying Relative" if the child satisfies the requirements in (A) and (B) and if the other person is not required to file a tax return and either does not file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of a taxpayer's non-working domestic partner.

12.4.9 Imputed Income Tax on Non-IRS Eligible Covered Dependents' Benefits

If you are active employees and have elected to enroll dependents who do not qualify for tax-free health benefits (such as non-spouse partners and some dependent children), the Group will:

a. Establish the fair market value of the Group's contribution for health coverage for these dependents;
b. Include this amount in your income when determining income and payroll taxes;
c. Report your income on your W-2
d. Withhold employee contributions for these dependents' coverage on a post-tax basis; and
e. Not permit Health Care Flexible Spending Accounts to be used for the reimbursement of these dependents' uninsured expenses.

SECTION 13. ENROLLMENT

This section explains how to enroll in the Plan. Once covered, it is your responsibility to inform the Group if an enrolled dependent ceases to be eligible due to divorce or other changes in status.

Duration of enrollment is effective for periods no shorter than one month. Exceptions include:

a. Partial first month enrollment immediately following the birth of an eligible child, the date of adoption of an eligible child or the date of placement for adoption of an eligible child; or
b. partial last month coverage for a subscriber immediately following their death.

13.1 WHEN THE EMPLOYEE FIRST BECOMES ELIGIBLE

New Hire: A submitted enrollment for the you and any dependents to be enrolled must be submitted within 31 days of subscriber's date of hire. If enrolling a spouse and/or domestic partner you must also complete a Declaration of Marriage or Domestic Partnership.

The amount of the employee's share of the monthly premium is different for full-time and/or part-time employees. Please review the enrollment brochure for the appropriate cost required to participate.

a. If enrollment is submitted within the 31 day enrollment period, **coverage begins on the first of the month following enrollment If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.**
b. If enrollment is not submitted within the 31-day enrollment period, you will be enrolled by default in the Plan and will not be able to change enrollment until the Group's next annual open enrollment period and you are provided with a 15-day period, following the default enrollment, to enroll eligible dependents.

13.2 ENROLLING NEW DEPENDENTS OF SUBSCRIBERS

You may obtain coverage for newly acquired or newly eligible dependents by completing enrollment and appropriate Declaration to the Group within 60 days of the eligibility event.

a. If enrollment is submitted during the 60-day enrollment period, **coverage for new dependent(s) begins on the first of the month following enrollment and receipt of an appropriate Declaration. If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.**
b. If enrollment is not submitted during the 60-day enrollment period, you may have to wait until the next annual enrollment period to add the new dependent.

Newborn children, adopted children and children placed for adoption are automatically covered for the first 31 days from birth, adoption or placement for adoption. To continue coverage, you must submit an enrollment within 60 days of birth, adoption or placement of adoption. Otherwise, coverage for the child will remain terminated on the 31st day post birth and you will not be unable to re-enroll the child until the next annual open enrollment (see section 13.4).

13.3 WAIVING DENTAL COVERAGE

You may elect to waive dental benefits offered by the Group but elect the Group's medical/vision/prescription coverage. You should refer to your labor agreement or Personnel Rule 110 for non-represented employee benefits for details.

If you waive dental coverage due to coverage under another group dental plan, and you subsequently lose that other coverage, you may enroll in the Plan within 60 days of losing the other coverage without waiting for the annual open enrollment period. In this situation, the dental coverage effective date will be the first day of the month following or coinciding with submission of an enrollment and documentation confirming the termination date of the other dental coverage.

If you waive dental coverage by choice (without having other dental coverage in force), you will be unable to change the choice to waive dental coverage until the next annual open enrollment period

13.4 ANNUAL OPEN ENROLLMENT

If you do not enroll a newly acquired dependent within 60 days of the eligibility event, the dependent can be enrolled during the Group's annual open enrollment period.

If you are newly hired and you fail to enroll any dependent within the 31 days following date of hire, such dependent will be able to enroll during the Group's annual open enrollment period or following a recognized IRS Family Status event, whichever is earlier.

13.5 SPECIAL ENROLLMENT RIGHTS

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled under the Plan, and either one loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

13.5.1 Loss of Other Coverage

If you decline coverage when initially eligible or at an open enrollment period because of other dental coverage, you or your dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. You stated in writing that you already had dental coverage when this Plan was first offered to you
b. You ask to enroll no more than 60 days after your prior coverage ended
c. You have a qualifying event. These are:
    i. Your prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted

ii. Your prior coverage ended 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. dissolution of domestic partnership
    C. loss of dependent status per plan terms
    D. death
    E. end of employment or reduction in the number of hours of employment
    F. reaching the lifetime maximum on all benefits
    G. the plan stops offering coverage to a group of similarly situated persons
    H. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
    I. termination of the benefit package option, and no substitute option is offered
iii. The employer contributions toward your other active (not COBRA) coverage end. If employer contributions stop, you or your dependent do not have to end coverage to be eligible for special enrollment on a new plan.
iv. Your prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility.

Coverage under special enrollment due to loss of coverage begins on the first day of the month following enrollment, or coinciding with, but not before the loss of other coverage.

13.5.2 Eligibility for Premium Subsidy

If you or your dependent are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment within 60 days of becoming eligible.

13.5.3 Acquisition of New Dependents by Subscribers

When you acquire a new dependent through birth, marriage, domestic partnership, adoption or placement of adoption, you, your spouse or domestic partner and children will have special enrollment rights if they are not enrolled at the time of the event that caused you to gain a new dependent.

No waiting period may apply, if enrollment is submitted within the 60-day enrollment opportunity. Coverage would be effective for those eligible to enroll on the following dates:

a. **Marriage:** The date coverage begins is determined by when enrollment is submitted. Once marriage has occurred, coverage begins the first day of the month following the date the Group receives the enrollment and Declaration of Marriage/Domestic Partnership. If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.
b. **Birth:** Infant is automatically covered for the first 31 days following birth. You should complete and submit enrollment. If enrollment is submitted within 60 days of the date of birth, the infant's coverage will be reinstated retroactive to the 31st day post birth.
c. **Adoption or placement for adoption**: Coverage begins on the date of the adoption or the placement date, following enrollment and adoption paperwork.

13.6 TERMINATION OF COVERAGE

When your coverage ends, coverage for all enrolled dependents also ends.

13.6.1 Termination of the Group Plan

Coverage ends for the Group and members on the date the Plan ends.

13.6.2 Termination by Subscriber

If you obtain other group dental coverage, or are covered as a dependent on other dental coverage, you may be able to terminate the coverage with the Group while still actively employed. You will need to submit an enrollment change and waive the dental coverage within 60 days from the date the new coverage starts. The Plan's coverage end date will be the last day of the month following receipt of the completed enrollment change request, or, if the first of the month is a business day and enrollment is processed that day, coverage will end on the last day of the prior month.

13.6.3 Death

If a subscriber who is an active employee dies, coverage for any enrolled dependents ends in accordance with the benefit termination rules (event occurring between 1st – 15th of a month cause a coverage end date at the end of that month; event occurring between 16th – 31st of a month causes coverage to end at the end of the following month). Enrolled dependents may extend their coverage for up to 36 months if the requirements for continuation of coverage (COBRA) are met (see section 17).

If a retired subscriber dies, coverage for any enrolled dependents ends at the end of the month. Enrolled dependents may extend their coverage for up to 36 months if the requirements for continuation of coverage (COBRA) are met (see section 17 for details).

If a covered COBRA subscriber dies, coverage for any enrolled dependents ends at the end of the month. Enrolled dependents may extend their coverage for up to 36 months (measured from the original COBRA event date) if the requirements for continuation of coverage (COBRA) are met (see section 17 for details).

If any subscriber dies, and the legal spouse or same sex domestic partner (when partnership is registered with the State of Oregon) is age 55 or older at the time of death, the enrolled legal spouse or state registered same sex domestic partner, and any enrolled dependent children under the Plan may continue their coverage under the Plan if they meet the requirements in section 13.6.13.

13.6.4 Loss of Eligibility

If you are no longer eligible, coverage will end for you and any enrolled dependents according to the terms described in the labor agreement or Personnel Rule 110 for non-represented employee benefits. However, you and enrolled dependents may have the right to continue coverage by purchasing the coverage on your own. See the "Continuation of Dental Coverage" section 17.

13.6.5 Rescission

Recission means canceling (rescinding) coverage back to the effective date, as if it had not existed. The Plan may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation. Examples of fraud and material misrepresentation include but are not limited to:

a. Enrolling someone who is not eligible
b. Giving false information or withholding information that is the basis for eligibility or employment
c. Submitting false or altered claims

The Plan has the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. You will be notified of a rescission decision 30 days before your coverage is canceled.

13.6.6 Family and Medical Leave

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

a. Affected members will remain eligible for coverage during the approved FMLA leave.
b. The subscriber's rights under FMLA will be governed by applicable state or federal statute and regulations.

If you are unpaid during a period of leave, your cost shares will be recovered by the Group upon your return to work.

13.6.7 Leave of Absence

If you are granted an unpaid, non-FMLA leave of absence by the Group, group sponsored coverage will end after the initial 30 days of leave, unless you return to work for the Group. If the employment termination date falls between the 1st and 15th of a month – the coverage end date is the last day of the same month. If the employment termination date falls between the 16th and the last day of a month – the coverage end date is the last day of the following month. Once the group sponsored coverage ends, you and any enrolled dependents may continue coverage under the Plan by purchasing the coverage on their own (see section 17).

A leave of absence is a period off work granted by the Group during which you are still considered to be employed and are carried on the employment records of the Group.

13.6.8 Strike or Lockout

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

Coverage cannot be continued if fewer than 75% of those normally covered continue coverage or if you otherwise lose eligibility under the Plan.

13.6.9 Termination of Employment

If your active employment terminates with the Group, coverage will end for you and all enrolled dependents. If the employment termination date falls between the 1st and 15th of a month – the coverage end date is the last day of the same month. If the employment termination date falls between the 16th and the last day of a month – the coverage end date is the last day of the following month. Members may have the opportunity to continue coverage under the Plan (see section 12.1.3 or section 17).

Should your active employment with the Group end, then you are rehired by the Group and return to active work within the same plan year:

If no open enrollment period has occurred during your absence: You and any previously enrolled dependents will be re-enrolled under the previous elected group dental plan. Coverage will begin on the first of the month following your rehire date, unless the rehire date (first working date) is the first of the month, then benefits will begin immediately. Example: Hire date October 1, First working day October 1, coverage restarts October 1. Example: Hire date October 1, First working day October 2, coverage restarts November 1.

If you have experienced a family status change during the leave, or return to work at a different FTE or Bargaining Unit: you may be able to request a change to the previous benefit elections (you can contact the Group for more information.)

If an open enrollment period occurred during your absence: You must complete and submit a Benefit Enrollment, as explained in the New Hire section, in order to enroll and initiate coverage. In this situation, you have the option of changing previous plan elections or keeping the same elections but the enrollment submission is required.

13.6.10 Termination of Coverage due to Reduction in Hours

If you experience a reduction in hours that causes loss of coverage, and subsequently experience an increase in work hours allowing you to qualify for benefits again:

If no open enrollment period has occurred during the period of non-coverage: You and any previously enrolled dependents will be re-enrolled under the previously elected group dental plan. Coverage will begin on the first of the month following your work hours increase date, unless the start date is the first of the month, then benefits will begin immediately.

You have experienced a family status change during the period of non-coverage/are working at a different FTE or Bargaining Unit: You may be able to request a change to the previous benefit elections (you can contact the Group for more information.)

If an open enrollment period occurred during the period of non-coverage: You must complete and submit a Benefit Enrollment in order to enroll and initiate coverage. In this situation, you have the option of changing your previous plan elections or keeping the same elections but the enrollment submission is required.

If you have unpaid employee cost shares remaining from a prior period of employment, they will be recovered by the employer upon your return to work to the extent permitted by law.

The Group must notify Delta Dental that you are being rehired following a termination of employment or your hours have been increased.

All Plan provisions will resume at the time you re-enroll whether or not there was lapse in coverage.

13.6.11 Loss of Eligibility by Children

An enrolled child will lose eligibility when one of these events occurs (whichever occurs first):

a. The child turns 26 years of age, or
b. The child reaches the age of majority or the age specified by the court, if the child is under your legal guardianship, or
c. A stepchild relationship ends due to divorce or end of domestic partnership
d. A grandchild ceases to meet the eligibility requirements specified in Section 12.4.6, or
e. A child with disability ceases to meet the eligibility requirements specified in Section 12.2.1.

Coverage will end on the last day of the month in which the child's eligibility ends. You will need to submit a timely request for the enrolled dependent's removal from coverage to the Group. You (or the dependent) may have the option to continue the dependent's coverage for up to 36 months by purchasing the coverage if the former dependent meets the requirements listed in section 17.

13.6.12 Loss of Eligibility by A Spouse or Domestic Partner

Coverage ends for an enrolled spouse or a domestic partner on the last day of the monthly period in which a decree of divorce or annulment is entered (regardless of any appeal) or domestic partnership is ended. However, you (or the spouse/domestic partner) have the option to continue the spouse/domestic partner's coverage for up to 36 months by purchasing the coverage if the former spouse/domestic partner meets the requirements listed in section 17.

Note

It is your responsibility to report an enrolled dependent's loss of eligibility in a timely manner. Failure to report a loss of eligibility event in a timely manner can cause a forfeiture of the terminated dependent's COBRA eligibility and, if benefit overpayment occurs, a financial responsibility for you.

13.6.13 Oregon Continuation Coverage for Spouses or State Registered Domestic Partners Age 55 and Over

a. Introduction

The Plan offers enrolled spouses and enrolled domestic partners the opportunity to request a temporary extension of dental coverage for themselves and their dependents if coverage is lost due to a specific event identified in the following paragraphs ("55+ Oregon Continuation").

Note: In section 13.6.13 the term "domestic partner" refers only to a registered domestic partner, as defined in section 5.

The Group is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group 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.

b. Eligibility Requirements for 55+ Oregon Continuation Coverage
Your enrolled spouse or domestic partner may elect 55+ Oregon Continuation coverage for themselves 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 state registered domestic partnership with the subscriber, or legal separation from the subscriber
b. Your spouse or domestic partner is 55 years of age or older at the time of such event
c. Your spouse or domestic partner is not eligible for Medicare

c. 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 Oregon State Registered domestic partnership, a legally separated or divorced spouse or domestic partner, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include the member's mailing address.

Notify the Group at:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 400
Portland, OR 97214

Notice of Death. Within 30 days of the death of the subscriber, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

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

d. Premiums for 55+ Oregon Continuation Coverage
Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date. Coverage is not in force unless premium payment has been received by the Group on month to month basis. The premium for this coverage generally changes each January 1.

e. When 55+ Oregon Continuation Coverage Ends

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

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan ends, unless a different group health plan is made available to group members
c. The date the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner becomes insured under any other group health plan
d. The date the member remarries or registers another domestic partnership
e. The date the member becomes eligible for Medicare.

13.6.14 Uniformed Services Employment & Reemployment Rights Act (USERRA)

Under USERRA, certain rights are guaranteed if you are an active employee and are called to active duty by any of the armed forces of the United States of America. However, the Group has elected to provide coverage in excess of what this law requires. While you are on active duty, coverage will be continued for the period of uniformed service leave. The Group will waive your cost shares that accumulate during this period not to exceed 5 years.

Should continuation coverage under USERRA be terminated or become exhausted, coverage will be reinstated on the first day you return to active employment with the Group if released under honorable conditions, but only if you return to active employment within time frames as set forth by the Group.

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 between discharge and your return to work, provided you have notified the Group of that illness or injury.

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

SECTION 14. CLAIMS ADMINISTRATION & PAYMENT

14.1 SUBMISSION AND PAYMENT OF CLAIMS

14.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

14.1.2 Dental Provider Claims

A dental provider may bill charges directly to Delta Dental. However, if the provider bills you directly, you should forward the bills to Delta Dental. The dental provider should use the billing form and the following must be shown on the bill:

a. The patient's name (who received treatment)
b. The subscriber's and Group's identification numbers
c. The date of treatment
d. An itemized description of services and charges

14.1.3 Explanation of Benefits (EOB)

We will report our action on a claim by providing you a document called an Explanation of Benefits (EOB). You are encouraged to access your EOBs electronically by signing up through your Member Dashboard. The EOB will show if a claim has been paid, denied, or the allowable expense has been applied toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If you do 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 we have not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 14.1.1.

If you received treatment from a participating Delta Dental dentist, the EOB will also report any amounts charged by the dentist that you will not be required to pay.

14.1.4 Claim Inquiries

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

14.1.5 Time Frames for Processing Claims

If a claim is denied, we will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond our control, a notice of delay will be sent to the member explaining those reasons within 30 days after we receive the claim. We will then finish processing the claim and send you an EOB no more than 45 days after receiving the claim. If more information is needed to process the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing

of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 14.1.1.

14.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

14.2.1 Definitions

For purposes of section 14.2, the following definitions apply:

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

Appeal is a written request by a member or the member's representative for Delta Dental to review an adverse benefit determination.

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

14.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

14.2.3 The Review Process

The Plan has a 2-level internal review process (a first level appeal and a second level appeal).

Note:
The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Delta Dental or the member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

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.

14.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records and other information relating to the claim for benefits may be submitted. Appeals are investigated by persons who were not involved in the original decision. Delta Dental will acknowledge receipt of the written appeal within 7 days and persons who were not involved in the original decision will investigate the appeal.

When an investigation is finished, Delta Dental will send a written notice of the decision to the member, including the reason for the decision. The investigation will be completed and notice sent within 30 days of receipt of the appeal.

14.2.5 Second Level Appeal

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions.

Investigations and responses to a second level appeal will follow the same timelines as those for a first level appeal. Delta Dental will notify the member in writing of the decision, including the basis for the decision, and, if applicable, information on the right to file suit under ERISA Section 502(a).

14.2.6 Additional Member Rights

Members are entitled to additional rights if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should check with the Group to determine if this section is applicable.

These first and second levels of review must be done before a member can file a lawsuit in court under ERISA Section 502(a). The right to file suit in court may be lost if the member has not used all of their internal appeal rights, which is generally required before filing a lawsuit.

14.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

14.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have dental coverage under more than one plan. A complete explanation of COB is in section 15.

14.3.2 Third Party Liability

You may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 14.3.3 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to you the Plan will pay your expenses based on the understanding and agreement that the Plan is entitled to be reimbursed from any recovery you

may receive for any benefits we paid that are or may be recoverable from a third party, as defined below.

You agree that the Plan has the rights described in section 14.3.2. The Plan may seek recovery under one or more of the procedures outlined in this section. You agree to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. We have discretion to interpret and construe these recovery and subrogation provisions.

14.3.2.1 Definitions:

For purposes of section 14.3.2, the following definitions apply:

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

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

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

14.3.2.2 Subrogation

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

14.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require you, and your attorney, if any, to protect its recovery rights. The following rules apply to all recovery, except for those related to motor vehicle accidents (see section 14.3.3 for motor vehicle recovery rights):

a. You hold any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.

b. The Plan is entitled to receive the amount of benefits we paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.

c. If this Plan is subject to ERISA, the Plan is not responsible for and will not pay any fees or costs associated with your pursuit of a claim against a third party. The Plan is entitled to full reimbursement, without discount and without reduction for attorney fees and costs. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies under the Plan. Only if the Plan is exempt from ERISA, you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

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

14.3.2.4 Additional Provisions

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

a. You shall cooperate with us to protect the Plan's recovery rights, including by:

   i. Signing and delivering any documents we reasonably require to protect the Plan's rights, including a Third Party Questionnaire and Agreement. If you have retained an attorney, then the attorney must also sign the agreement.
   ii. Providing us with any information relevant to the application of the provisions of section 14.3.2 including all information available to you, or any representative or attorney representing you, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.
   iii. Notifying us of the potential third party claim for which the Plan may issue benefits. You have this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by your provider.
   iv. Taking such actions as we may reasonably request to assist it in enforcing the Plan's third party recovery rights.

b. You and your representatives are obligated to notify us 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 you are seeking recovery of benefits paid by the Plan from the third party.

c. By accepting payment of benefits by the Plan, you agree that we or the Plan have the right to intervene in any lawsuit or arbitration filed by you or on your behalf seeking damages from a third party.

d. You agree that we may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 14.3.2.

e. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 14.3.2.

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

g. If you continue to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that you can establish that any sums that may have been recovered from the third party have been exhausted.

h. If you or your representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits we have advanced, for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim, except for claims related to motor vehicle accidents (see section 14.3.3). The Plan may notify dental providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

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

14.3.3 Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Delta Dental and motor vehicle insurance has not yet paid, then the Plan will advance benefits. The Plan retains the right to repayment of any benefits paid from the proceeds of any settlement, judgment or other payment received by you that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If the Plan requires you and your attorney to protect its recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You shall do whatever is proper to secure, and may not prejudice, the rights of the Plan under this section.

SECTION 15. COORDINATION OF BENEFITS

15.1 DEFINITIONS

For purposes of section 15, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. Separate contracts do not include dual coverage when you and the spouse of domestic partner are employed by the Group and are covered as both subscribers and dependents.

Plan includes:

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

Plan does not include:

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

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

Complying plan is a plan that follows these COB rules.

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

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

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

This Plan is the group health plan 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 this group health plan providing dental benefits is separate from this Plan. A group health plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

15.2 HOW COB WORKS

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

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

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

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 you use 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 may process its payment before the primary plan pays the claim. This Plan will process the claim based on an estimate of the primary plan's benefit being equal to this Plan's benefit.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than the member 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 the Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

15.3 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, (e.g., an employee, member of an organization, primary insured or retiree) then that plan will determine its benefits before a plan that covers the member as a dependent.
b. **Dependent/Spouse (or Domestic Partner) and Parents.** For a dependent covered under plans of a spouse or domestic partner and the dependent's parents, the spouse's or domestic partner's plan is primary. The order of the parents' plans should follow the first applicable provision (c or d) below. This rule does not apply if the non-dependent/dependent rule can determine the order of benefits. Once future state or federal guidelines are issued to determine the order of coverage when a dependent is covered under plans of a spouse or domestic partner and the dependent's parents.
c. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)

d. **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 domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent
e. **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.
f. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
g. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., 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.
h. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
i. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
j. **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 if it had been the primary plan.

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

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

SECTION 16. MISCELLANEOUS PROVISIONS

16.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, you must give or authorize a provider to give us any information needed to pay benefits. We may release to or collect from any person or organization any needed information about you.

16.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping your protected health information confidential is very important to the Plan. Protected health information includes enrollment, claims, and medical and dental information. Such information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses members' information. Delta Dental, as the claims administrator, is required to follow these same practices. Members may contact the Group if they have additional questions about the privacy of information beyond what is provided in the Notice of Privacy Practices.

16.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental or the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider upon a member's written request.

16.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

16.5 CORRECTION OF PAYMENTS

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

16.6 CONTRACT PROVISIONS

The agreement between Delta Dental and the Group, including 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 in the contract. This handbook and the agreement plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

16.7 WARRANTIES

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

16.8 LIMITATION OF LIABILITY

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

16.9 PROVIDER REIMBURSEMENTS

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

16.10 INDEPENDENT CONTRACTOR DISCLAIMER

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

16.11 No Waiver

Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If the Plan delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

16.12 Group is the Agent

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

16.13 Governing Law

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

16.14 Where any Legal Action Must be Filed

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

16.15 Time Limit for Filing a Lawsuit

Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 14.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

SECTION 17. CONTINUATION OF DENTAL COVERAGE

17.1 COBRA CONTINUATION COVERAGE

17.1.1 Introduction

The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. Other than an exception to offer domestic partner coverage, the Plan is not obligated to offer greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the requirements outlined below

For purposes of section 17.1, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

17.1.2 Qualifying Events

a. **Subscriber.** You may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct on your part), or a reduction in hours.

b. **Spouse or Domestic Partner.** Your spouse or domestic partner has the right to continuation coverage if coverage is lost for any of the following qualifying events:

   i. Death of the subscriber
   ii. Termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Group
   iii. Divorce from the subscriber
   iv. Termination or dissolution of a qualifying domestic partnership
   v. You become entitled to Medicare

If it can be established that you have eliminated coverage for your spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though your ex-spouse lost coverage earlier. If your ex-spouse notifies the COBRA Administrator within 60 days of the divorce, COBRA coverage may be available for the period after the divorce.

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

   i. Death of the subscriber
   ii. Termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Group
   iii. Parents' divorce or termination of a qualifying domestic partnership
   iv. You become entitled to Medicare
   v. Child ceases to be a child under the Plan

17.1.3 Other Coverage

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

17.1.4 Notice and Election Requirements

Qualifying Event Notice. Your dependent's coverage ends on the date according to section 10.6 when a divorce or legal separation or termination or dissolution of domestic partnership occurs (spouse's or domestic partner's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, you or a family member have the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following:

1) the name of the Group
2) the name and personal identification number of the affected members
3) the affected members
4) the event (e.g., divorce); and
5) the date the event occurred.

Notice must be given to the COBRA Administrator no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available. Notice should be sent by email or mail to:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 400
Portland, OR 97214
employee.benefits@multco.us

Election Notice. Members will be notified of their right to continuation coverage and the process for completing COBRA enrollment and premium payment within 14 days after the COBRA Administrator receives a timely qualifying event notice. COBRA coverage is not in force until enrollment is complete and premium payment is made. If you or dependent fail to provide notice of a qualifying event within the 60 day period, COBRA continuation of coverage will not be available.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage:

1) your termination of employment (other than for gross misconduct)
2) Your reduction in hours
3) death of the subscriber
4) Your becoming entitled to Medicare

Election Process (Member Responsibility). A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage will end on the date determined by the qualifying event. Elected COBRA coverage is not in force until premium has been paid.

You or your spouse may elect continuation coverage for eligible family members. However, each family member also has an independent right to elect COBRA coverage. This means that your spouse or child may elect continuation coverage even if you do not.

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

17.1.5 COBRA Premiums

Members eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the COBRA premium payment date.

Subsequent payments are due on the first day of the month. For example, premium for October coverage is due on October 1. However, there will be a grace period of 30 days to pay the premiums (for example, a member would have until October 31st to pay the October premium). Payment of premium received after the due date but within the grace period may result in delayed access to coverage. Monthly eligibility is not updated until premium payment is received.

The COBRA administrator will not send a monthly bill for any payments due. The member is responsible for paying the applicable premiums, in good funds, when due, **otherwise continuation coverage will end and may not be reinstated**. The premium rate may include a 2% add-on to cover administrative expenses.

17.1.6 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost 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. When coverage is lost due to a subscriber's death, divorce, termination or dissolution of a qualified domestic partnership, 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 your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members (other than yourself) 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 you become entitled to Medicare within 18 months before the termination or reduction of hours.

17.1.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, the member will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from your termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period. Each family member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

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

If the Social Security Administration determines the member is no longer disabled, the disability extension ends. The member must notify the COBRA Administrator no more than 30 days after the Social Security Administration's determination that they are no longer disabled.

Second Qualifying Event. An extension of coverage will be available to spouses or domestic partners and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following your 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. Second qualifying events may include the death of a subscriber, divorce, termination of a qualified domestic partnership 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 member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when you become entitled to Medicare after your termination of employment or reduction of hours.)

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

Note: Longer continuation coverage may be available under Oregon law for your spouse or domestic partner age 55 and older who loses coverage due to your death, or due to legal separation or divorce or dissolution of marriage or domestic partnership (see section 13.6.13).

17.1.8 Newborn or Adopted Child

If, a child is born to or placed for adoption with you, the child is considered an eligible member. You may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (e.g., age). You or a family member must notify the COBRA Administrator within 60 days of the birth or placement to obtain coverage. If the COBRA Administrator is not notified in the required timeframe, the child will not be eligible for coverage.

17.1.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. You may add children, spouses, or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 12.4 and 13.2), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

17.1.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. Any required premiums are not paid in full on time
b. A member becomes covered under another group dental plan
c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA.
d. The Group ceases to provide any group dental plan for its employees
e. During a disability extension period (section 17.1.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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

Questions about COBRA should be directed to the COBRA Administrator. You should notify the COBRA Administrator if there is a changed marital status a change of addresses, or other changes that may impact eligibility for COBRA continuation coverage.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 0569 (8/20)

DELTA DENTAL

Delta Dental of Oregon & Alaska

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនសោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

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