DELTA DENTAL®

2025

Oregon Group Dental Plan

Multnomah County
Delta Dental PPO 50 Plan
Classes: 0001, 0002, 0003, 0004, 0005, 0006, 0007, 0008, 0009, 0010, 0011, 0013, 0014 and 0015
January 1, 2025
10001684

Multnomah County

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SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON

Funding Medium and Type of Plan Administration: The Plan is self-funded. This means money that pays your claims comes from the Group. We are pleased your Group has chosen Delta Dental to provide claims and administrative services. Where this book talks about Delta Dental paying claims, it means we are issuing benefits that the Group is providing (paying).

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.

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 it to find an in-network dentist)

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

Appeals Department
P.O. Box 40384
Portland, OR 97240
Fax 503-412-4003

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers. Show your card each time you receive services, so your dentist will know you are a Delta Dental member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

2.3 NETWORK

Network Information (section 3.1) explains how networks work. This is the network for your Plan.

Dental networks
Delta Dental PPO
Delta Dental Premier

2.4 OTHER RESOURCES

You can find other general information about the Plan in Section 13.

SECTION 3. USING THE PLAN

If you have questions about the Plan, contact Customer Service.

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

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

3.1 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 the dentist's office and us. If you are outside Oregon, Delta Dental Plans Association provides offices and/or contacts in every state. We can process dental claims for services you get any place in the world.

If you need dental care, you may go to any dental office. **There are differences in how the Plan pays for in-network Delta Dental PPO dentists or Delta Dental Premier dentists and out-of-network dentists or dental care providers.** You may choose to use any dentist, but we cannot guarantee that any particular dentist will be available.

3.1.1 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 and fees actually charged.

3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist or dental care provider is 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 maximum allowed amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, we provide a predetermination service. Your dentist may send us a predetermination request to get an estimate of what the Plan would pay. We will process the request according to the Plan's current benefits and return it to your 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 4. 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). They are only covered when they are determined to be necessary and customary by the standards of generally accepted dental practice to prevent or treat oral disease or accidental injury. Our dental consultants and dental director determine these standards.

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

Covered dental services are grouped in 3 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services and are noted below. See Section 8 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 you get them from 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 1 through December 31). 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 except orthodontia apply to the annual maximum plan payment limit. See separate Orthodontia benefit information in Section 7. You will have to pay any amount over the annual maximum plan payment limit and maximum orthodontic payment limit.

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

4.1.1 Diagnostic

a. Diagnostic Services:

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

b. Diagnostic Limitations:

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

4.1.2 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 4.1.2.a.i).
ii. Adult prophylaxis is only covered if you are age 12 and over. Child prophylaxis is covered if you are under age 12.
iii. Topical application of fluoride is covered if you are under age 23.
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealants are only covered on the unrestored occlusal surfaces of permanent bicuspids and molars. Benefits are 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 covered for one space per quadrant if you are under age 14. Space maintainers for primary anterior teeth or missing permanent teeth or if you are age 14 and over are not covered.

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

4.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings to treat 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. We will pay an alternate benefit of a composite filling. **The member is responsible for paying the difference.**
iii. Crown buildups are included in the crown restoration cost. A buildup is covered 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 2 years of placement is not covered. The replacement is included in the charge for the original crown.
vi. See section 4.3.1 for additional limitations when teeth are restored with crowns or cast restorations.

4.2.2 Oral Surgery

a. Oral Surgery Services:

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

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done along 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 after 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.

4.2.3 Endodontic

a. Endodontic Services:

i. Procedures to treat 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 covered. 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.

4.2.4 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 after 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. If you are age 19 or older, it is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2 years.

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 us prior to treatment for verification of coverage for proposed treatment.

d. Palliative Treatment:

i. Emergency services primarily for relief, not cure.

4.2.5 Anesthesia

a. General anesthesia or IV sedation

Covered only:

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

4.2.6 Miscellaneous

a. Miscellaneous Services:

i. Nitrous oxide

4.3 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.

4.3.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-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 4.2.1.b.iii)

ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. We will pay for a gold restoration, **and you will have to pay the difference**.

iii. If your tooth can be restored by an amalgam or composite filling, but you or your dentist choose another type of restoration, the covered expense is limited to a composite. Crowns are only covered 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. A separate, additional charge to repair a restoration done within 2 years of the original restoration is not covered.

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

4.3.2 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 is covered once in a 7-year period and only if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last 7 years.

ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount is 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 covered when placed within 2 months of the extraction of an anterior tooth or to replace missing anterior permanent teeth for members age 16 or under. If a specialized or precision device is used, covered expense is limited to the cost of a standard cast partial denture.

Cast restorations for partial denture retainer teeth are not covered unless the tooth requires a cast restoration because it is 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 are 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. These benefits are limited to once per tooth or tooth space over the lifetime of the implant
    B. 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
    C. The final implant-supported bridge retainer and implant abutment, or pontic. This benefit is limited to once per tooth or tooth space over the lifetime of the implant
    D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth
    E. This benefit or alternate benefits is not provided if the tooth, implant or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years

vii. Re-cementing or re-bonding an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.

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. **You will have to pay the difference.**

ix. Fixed bridges or removable cast partial dentures are not covered if you are under age 16.

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 7 years since the last purchase.

xi. An athletic mouthguard is covered once in any 12-month period if you are under age 16 and once in any 2-year period if you are age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are not covered.

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 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 other provider are not covered. Repair or reline and adjustment of occlusal guard is covered once every 12-month period.

4.4 General Limitation – Optional Services

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

4.5 Intellectual and Developmental Disabilities

For members with intellectual or developmental disabilities, we cover some extra services to help them get the dental care they need:

a. Visits before the first treatment, to help members learn what to expect
b. Up to 2 extra cleanings per year
c. Silver diamine fluoride to stop the progression of cavities for members who cannot tolerate the use of certain dental instruments
d. Sedation
e. Dental case management for members with special healthcare needs (such as sensory issues, behavioral challenges, severe anxiety) that make dental care difficult

Call Customer Service to find out how to get these extra benefits.

SECTION 5. ORAL HEALTH, TOTAL HEALTH BENEFITS

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

5.1 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 described in Section 4.

5.1.1 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 your 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.

5.1.2 Pregnancy

Keeping your mouth healthy during a pregnancy is important for you and your baby. According to the American Dental Association, if you are pregnant and have periodontal (gum) disease, you 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 people whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during your third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. If you are pregnant, you are eligible for a cleaning in the third trimester of pregnancy.

5.2 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. If you have diabetes, you must include proof of diagnosis.

SECTION 6. HEALTH THROUGH ORAL WELLNESS

The Plan offers enhanced benefits through Delta Dental's Health through Oral Wellness program (see section 6.3) if you are 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.

6.1 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, log in to your Member Dashboard account at www.DeltaDentalOR.com and click on 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 ask Customer Service for help finding a dentist registered with the program.

6.2 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.

6.2.1 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 to stay eligible. You will qualify for enhanced benefits regardless of your risk score for tooth decay at a subsequent risk assessment provided there is no lapse in your eligibility.

6.2.2 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 to stay eligible. You will qualify for enhanced benefits regardless of your risk score for gum disease at a subsequent risk assessment provided there is no lapse in your eligibility.

6.2.3 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 to stay eligible. Your oral cancer risk score may affect your eligibility for enhanced benefits. See section 6.4 for more information.

6.3 ENHANCED BENEFITS

6.3.1 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. Additional prophylaxis (cleaning) or periodontal maintenance,
b. Additional fluoride varnish or topical fluoride,
c. Additional 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.

6.3.2 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.

6.3.3 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 5.

6.4 WHEN ENHANCED BENEFITS END

If you do not receive continued clinical risk assessments as required in section 6.2, you will lose your eligibility for enhanced benefits. Standard plan benefits, see Section 4, 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 7. ORTHODONTIC BENEFIT

7.1 ORTHODONTIC BENEFIT

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

The Plan covers 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 pays $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.

7.2 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 will 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 8. EXCLUSIONS

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, procedures and conditions are not covered, even if they are dentally necessary, they relate to a condition that is otherwise covered, or they are 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 4.2.5

Behavior Management
Additional services, time or assistance to control the actions of a member (except as stated in section 4.5)

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

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

Congenital or Developmental Malformations
Includes treating 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
Any service or supply with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in dental function. Examples include, tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

Experimental or Investigational Procedures
Including expenses related to or needed because 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 to treat an injury or condition caused by or arising directly from your illegal act

Inmates
Services and supplies you get 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 described in section 4.5 for IDD and except as allowed under Health Through Oral Wellness as seen in Section 6

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

Maxillofacial Prosthetics
Except surgical stents as stated in section 4.3.2

Medications
Except as allowed under Health Through Oral Wellness (Section 6) . (Prescriptions for pain or infection may be eligible for coverage under your prescription medication benefit 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 4.3.2. 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 your medical plan

Services Otherwise Available
Someone else should have been responsible for the cost of these services or supplies. Examples include when payment or compensation should be provided by:

a. Workers' compensation or employer's liability laws
b. Any city, county, state or federal law, except Medicaid
c. Any municipality, county or other political subdivision or community agency without cost to you, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. Separate contracts that are used to provide coordinated coverage 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 to treat illness or injury that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 9.3.2)

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ) (except for nightguards in section 4.3.2)

Translation and Sign Language Services
Included in the fees for overall patient management and are not covered separately

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

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services and supplies that are:

a. Not dentally necessary to treat or prevent a dental injury or disease otherwise covered under the Plan
b. Inappropriate with regard to standards of good dental practice
c. Have a poor prognosis

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

Treatment of Closed Fractures

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION AND PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim no more than 12 months after the date of service
b. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service.

The date of service is the date you receive the service or supply. You must actually receive the service or supply before we will pay the claim.

9.1.1 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

9.1.2 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). We may pay claims, deny them or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 9.1.

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.

9.1.3 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 your inquiry within 30 days.

9.1.4 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

a. If the claim is denied, we will send an EOB explaining the denial
b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it.
c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send

it to us. We will finish processing the claim no more than 15 days after we get the additional information.

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 9.1.

9.2 APPEALS

Before you file an appeal, call Customer Service. We may be able to resolve your problem over the phone.

9.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

a. You have **180 days** from the date you receive an adverse benefit determination to send us your first level appeal
b. You have **60 days** from the date of the first level appeal decision to send us your second level appeal

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see "Filing an Appeal" in Section 13). Describe what happened and what outcome you are hoping for. Include dental records or other documentation that will help us investigate your appeal.

9.2.2 The Review Process

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

You may review the claim file and submit written comments, documents, records and other information to support your appeal.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time. If you need help, ask Customer Service
b. We will acknowledge receipt of the written appeal within 7 days and persons who were not involved in the original decision will investigate your appeal
c. We will send the decision to you within 30 days

Special Circumstances

The timelines for reviewing your appeal do not apply if:

a. You do not reasonably cooperate
b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises

9.2.3 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination is a letter or an Explanation of Benefits (EOB) from us telling you that you are not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Eligibility to participate in the Plan
b. Utilization review (described below)

c. Limitations or exclusions described in Section 4 or Section 8 including a decision that an item or service is experimental or investigational or not dentally necessary

Appeal is a written request by you or your representative for us to review an adverse benefit determination.

Utilization Review is how we review the dental necessity, appropriateness or quality of dental care services and supplies. These adverse benefit determinations are examples of utilization review decisions:

a. The care is not dentally necessary or appropriate
b. The care is investigational or experimental
c. The decision about whether a benefit is covered involved a dental judgment

9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have dental coverage under more than one plan. 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 Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first.

COB can be very complicated. This is a summary of some of the more common situations where you may have double coverage. It is not a full description of the COB rules. If your situation is not described here, contact Customer Service for more information.

9.3.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

a. The subscriber's own dental expenses
b. Your covered child's expenses when you are the subscriber and
    i. Your birthday falls earlier in the year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
    ii. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
    iii. If you are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

9.3.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the

primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses

a. We will calculate the benefits we would have paid if you did not have any other dental coverage. We will apply that amount to any allowable expense that the primary plan did not pay
b. We will credit any amounts to the deductible that would have been applied if you did not have other dental coverage
c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
d. If the primary plan did not cover an expense you did not follow that plan's rules, we will not cover that expense either. An example is if you have a lower benefit from your primary plan because you did not use an in-network provider

If the primary plan is a closed panel plan (HMO is an example) and you use an out-of-network provider, we will provide benefits as if we are the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Any plan that does not follow Oregon's COB rules is always primary.

9.3.1.3 Definitions

For purposes of section 9.3.1, the following definitions apply:

Plan is any of the following that provide benefits or services for medical or dental care or treatment:

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

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.

If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan does not include:

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

Allowable expense is a dental expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead

of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

These are not allowable expenses:

a. Any expense is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you

9.3.2 Third Party Liability

The rules for third party liability, including motor vehicle and other accidents, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

The Plan does not cover benefits when someone else (a third party) is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and agreement that the Plan is entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party.

You agree to do whatever is necessary to fully secure and protect the Plan's right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate with us to protect the Plan's subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect the Plan's rights and providing any information or taking any actions that will help us recover costs from a third party. We have discretion to interpret these recovery and subrogation provisions.

a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for the Plan.

b. The Plan is entitled to be reimbursed for any benefits the Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. The Plan is entitled to receive the amount of benefits the Plan has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.

c. If this Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies under the Plan. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.

d. 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 9.3.2.

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

f. Section 9.3.2 applies you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Delta Dental.

If you or your representatives do not comply with the requirements in this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any sickness, illness, injury or dental/medical condition related to the third party claim, except for claims related to motor vehicle accidents (see section 9.3.2.1). We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

9.3.2.1 Motor Vehicle Accident Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we will advance benefits. The Plan has the right to be repaid from the proceeds of any settlement, judgment or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If we require you or your attorney to protect the Plan's 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 will do whatever is required to secure, and may not prejudice, our rights under this section.

SECTION 10. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

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.

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.

10.1 SUBSCRIBER

10.1.1 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), regular status, or limited duration non-represented position for the Group.

10.1.2 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 regular or limited duration position for the Group.

10.1.3 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.

10.1.4 COBRA Eligibility

You may be able to continue coverage under COBRA provisions if you are no longer eligible for coverage under this Plan. You should check with the Group's benefits office to find out whether or not you qualify for COBRA (see Section 11). Benefits under COBRA continuation are the same as the current Plan.

10.2 WHEN THE EMPLOYEE FIRST BECOMES ELIGIBLE

New Hire: A submitted enrollment for you and any dependents to be enrolled must be submitted within 31 days of your date of hire. If enrolling a spouse 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 Group's current plan information 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 on or following enrollment.**
b. If enrollment is not submitted within the 31-day enrollment period, and you are a full-time employee, 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. You are provided with a 15-day period, following the default enrollment, to enroll eligible dependents.

To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You are eligible to remain enrolled if you are on an approved leave of absence under state or federal family and medical leave laws.

You must tell us and the Group if your address changes.

10.3 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**. 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.

Children with Disabilities
A subscriber's child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even though they are over 26 years old. If the child is eligible for over-age coverage under the medical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, you must send us the medical carrier's determination that the child is eligible for over-age coverage to Delta Dental at least 45 days before the child's 26th birthday to avoid a break in coverage.

10.4 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 on or following enrollment and receipt of an appropriate Declaration.**
b. If enrollment is not submitted during the 60-day enrollment period, or requested supplemental documentation for the dependent is not provided to the Group, 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. You must submit enrollment within 60 days of birth, adoption or placement for adoption to continue coverage beyond the first 31 days. Otherwise, coverage for the child will remain terminated on the 31st day post birth, adoption or placement for adoption and you will not be able to re-enroll the child until the next annual open enrollment (see section 10.6).

10.4.1 New Dependents of Subscribers
Generally you have 60 days from the date you gain a new dependent 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, or requested supplemental documentation for the dependent is not provided to the Group, you may have to wait until the next annual open enrollment in order to add the new dependent to coverage.

10.4.2 Marriage
If you marry while covered under the Plan, your spouse and their 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.

10.4.3 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.

10.4.4 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.

10.4.5 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.

10.4.6 Newborn Child

Your newborn child is automatically covered 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.

10.4.7 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,
b. You must submit enrollment for the grandchild within 60 days of birth,
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

d. Both the grandchild and birth parent reside in your home, and
e. You must submit an affidavit attesting to these facts to the Group

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 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.

10.4.8 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.

To continue coverage beyond the first 31 days, enrollment is required. The enrollment and any requested supplemental documentation 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.

10.4.9 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:

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.

10.4.10 Imputed Income Tax on Non-IRS Eligible Covered Dependents’ Benefits

If you are an 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

Not permit Health Care Flexible Spending Accounts to be used for the reimbursement of these dependents’ uninsured expenses.

10.5 WAIVING DENTAL COVERAGE

You may elect to waive dental benefits offered by the Group but elect the Group’s medical/vision/prescription coverage.

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.

10.6 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, you will be able to enroll such dependent during the Group's annual open enrollment period or following a recognized IRS Family Status event, whichever is earlier.

10.7 SPECIAL ENROLLMENT

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 spouse or domestic partner if neither is enrolled in the Plan, and either 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.

10.7.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other dental coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

a. You ask to enroll no more than 60 days after your prior coverage ended
b. You have a qualifying event. These are:
    i. Your other coverage ended because you were no longer eligible. Examples of when this happens include:
        A. loss of dependent status per plan terms, including divorce or legal separation
        B. dissolution of domestic partnership
        C. end of employment or not working enough hours
        D. reaching the lifetime maximum on all benefits
        E. the plan stops offering coverage to a specific group of similarly situated persons
        F. moving out of an HMO service area and the plan does not have another option
        G. the benefit package option is canceled, and no substitute option is offered
    ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility.
    iii. You exhausted your COBRA continuation coverage

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before the loss of other coverage.

10.7.2 Payment Changes

You may have special enrollment rights when there are changes to how your premiums are paid:

a. Employer contributions toward your other active coverage (not COBRA coverage) end.

b. If you 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.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before the premium contribution or subsidy change.

10.7.3 Gaining New Dependents by Subscribers

When you acquire a new dependent through birth, marriage, domestic partnership, adoption or placement for 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 on or following the date the Group receives the enrollment and Declaration of Marriage/Domestic Partnership.
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.

10.7.4 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in the Plan. All other plan provisions will apply.

10.8 TERMINATION OF COVERAGE

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

10.8.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends.

10.8.2 Subscriber Ends Coverage

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 on or following receipt of the completed enrollment change request, or, if the request is received the first day of the month, coverage will end on the last day of the prior month.

10.8.3 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 causes 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 11.1).

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 11.1 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 11.1 for details).

If any subscriber dies, and the legal spouse or 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 domestic partner, and any enrolled dependent children under the Plan may continue their coverage under the Plan if they meet the requirements in section 10.8.13.

10.8.4 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 4-20 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 11.

10.8.5 Rescission

Rescission 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 told of a rescission decision 30 days before your coverage is canceled.

10.8.6 Family and Medical Leave

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will re-start as if there had been no break in coverage.

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

10.8.7 Leave of Absence

If you are granted an unpaid, non-Family Medical Leave Act/Oregon Family Leave Act/Paid Leave Oregon/Washington Paid Family and Medical Leave 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 30 days after the last day in paid status falls between the 1st and 15th of a month – the coverage end date is the last day of the same month. If 30 days after the last day in paid status 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 your own (see Section 11).

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.

10.8.8 Strike or Lockout

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Group, to the union or trust. The union or trust must send the premiums to the Group when due.

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. You become employed full-time with another employer
c. You lose eligibility under the Plan for other reasons

10.8.9 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 10.1.3 or Section 11).

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.

10.8.10 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 on or following the date you become eligible for coverage again.

If you have experienced a family status change during the period of non-coverage or 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.

10.8.11 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 10.4.7, or
e. A child with disability ceases to meet the eligibility requirements specified in Section 10.3.

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 11.

10.8.12 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 11.

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.

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

55+ Oregon Continuation applies to employers with 20 or more employees. It provides continuation coverage for spouses and domestic partners age 55 and older who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the following requirements:

You must notify the Group or its third party administrator in writing within 60 days from the date your marriage or domestic partnership is legally ended or within 30 days after the subscriber has died. Include your mailing address. Notify the Group at:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 320
Portland, OR 97214

You will be given information about how to sign up for continuation coverage and pay premiums. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise, 55+ Oregon Continuation ends when you become insured under any other group dental plan, you become eligible for Medicare or remarry or register another domestic partnership.

Note: For 55+ Continuation, the term "domestic partner" refers only to a registered domestic partner, as defined in Section 12.

10.8.14 Uniformed Services Employment & Reemployment Rights Act (USERRA)

If you are called to active duty by any of the armed forces of the United States of America, you may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group. You can get complete information about your rights under USERRA from the Group.

SECTION 11. CONTINUATION OF DENTAL COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

11.1 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct, or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse/domestic partner or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than termination for gross misconduct on their part) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. Termination or dissolution of a qualifying domestic partnership*
f. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g., divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available. Notice should be sent by email or mail to:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 320
Portland, OR 97214
employee.benefits@multco.us

Electing COBRA
You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is

postmarked, if mailed, or the date the COBRA Administrator receives it, if hand delivered). The premium rate may include a 2% add-on to cover administrative expenses.

All other payments are due on the 1st day of the month. You will not receive a bill. You are responsible for paying your premiums when due. COBRA coverage is not in force until enrollment is complete and premium payment is made. If you or your dependent fail to provide notice of a qualifying event within the 60 day period, COBRA continuation of coverage will not be available. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period 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.

Length of COBRA

COBRA due to end of employment (other than for gross misconduct) or a reduction of hours of employment generally lasts up to 18 months. COBRA because of the 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, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family might be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period.

You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 60 days after the latest of:

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

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premium. Your disability extension ends if you are no longer considered disabled.

If you are a spouse, domestic partner or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, termination of a qualified domestic partnership from the

subscriber, or a child's no longer being eligible as a dependent under the Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 10.8.13).

When COBRA Ends
COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group dental plan to its employees. COBRA will also end if:

a. You become covered under another group dental plan
b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud).

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes. 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.

***Special Circumstances**
References to spouse within the COBRA section may apply to a domestic partner, unless otherwise stated. For divorce or legal separation, termination of domestic partnership applies for domestic partners.

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

SECTION 12. DEFINITIONS

Alveolar Structures are the upper and lower jaw bones.

Alveoloplasty is the shaping of the bone of the upper or the lower jaw. It is most commonly done in conjunction with the removal of a tooth or teeth so the gums heal smoothly for the placement of partial denture or full denture.

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

Anterior refers to teeth located at the front of the mouth (tooth chart in Section 14).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in Section 14).

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. If your coinsurance is 20%, you pay 20% of the covered charge and we pay the other 80%.

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. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network providers or the cost of non-covered services.

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

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

Deductible is the amount of covered expenses you must pay before the Plan starts paying.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. References to Delta Dental as paying claims or issuing benefits means that Delta Dental processes a claim and the Plan Sponsor reimburses Delta Dental any benefit issued. Where this book refers to “we”, “us”, or “our” it is referring to Delta Dental or its employees.

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 to prevent 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 is a licensed dentist operating within the scope of their license.

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

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

a. **State Registered Domestic Partner** is 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** is 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.

Domestic Partnership or Marriage Documentation is a signed document that attests the subscriber and one other eligible person meet the criteria in the document to be a spouse or domestic partner. Document is required by the Group from every employee who seeks to enroll a spouse or domestic partner for dental plan coverage.

Eligible Employee refers to any person who:

a. is a regular status 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 are services for a dental condition with acute symptoms of sufficient severity that requires immediate treatment. Includes services to treat acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

Enrollment Date is, 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 Plan to provide claims and other administrative services. It also means the Plan Sponsor.

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 that connects 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 is a licensed dentist who contracts in the preferred provider network (PPO) to provide dental care to you.

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

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 is 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 done every 6 months.

Periodontal Maintenance is a periodontal procedure done when you have been treated for periodontal disease. This is a more comprehensive service than a regular cleaning (prophylaxis), where surfaces below the gum-line are also cleaned.

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

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

Posterior refers to teeth located toward the back of the mouth (tooth chart in Section 14).

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

Prophylaxis is cleaning and polishing the visible surfaces of all teeth.

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

Restoration is treatment that repairs a broken or decayed tooth. Restorations include fillings and crowns.

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

Subscriber is 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 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 MISCELLANEOUS PROVISIONS

Contract Provisions
The agreement between Delta Dental and the Group and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained 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.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims. It is also used for referrals , case management and quality management programs. We do not sell your information. The Group's Notice of Privacy Practices has more detail about how we use your PHI. Contact the Group if you have other questions about privacy.

Right to Collect and Release Needed Information
You must give us, or authorize a provider to give us, any information we need to pay benefits. We may release to or collect from any person or organization any needed information about you.

Transfer of Benefits
Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except to the provider.

Correction of Payments or Recovery of Benefits Paid by Mistake
If Delta Dental makes a payment for a member to which they are not entitled or pays a person who is not eligible for payments at all, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf.

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.

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.

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

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.

Responsibility for Quality of Dental Care
You always have the right to choose your dental provider. We are not responsible for the quality of your dental care. Your dentists act as independent contractors. We cannot control the detail, manner or methods by which a participating dentist provides care.

We cannot be held liable for the negligence of any dentist providing services to you. Nothing contained in the Plan shall be construed as obligating Delta Dental to provide dental services to you.

Provider Reimbursements
Dentists contracting with Delta Dental to provide services to you agree to look only to the Plan for payment of the part of the expense that is covered by the Plan. They may not bill you if the Plan fails to pay the dentist for whatever reason. The dentist may bill you for applicable cost sharing (such as coinsurance or deductible) or non-covered expenses except as may be restricted in the provider contract.

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.

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.

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 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

Notices
Any notice to you, to a provider or to the Group that we are required to provide is considered properly given if written notice is deposited in the U.S. mail or with a private carrier. Notices will be addressed to the last known address in our records. If we receive a U.S. Postal Service change of address form, we will update our records with that new address. We may forward a notice for

you to the Group if we become aware that we do not have a valid mailing address for you. Any notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

Filing an Appeal
You can file an appeal or complaint by writing a letter to Delta Dental. Include the following information:

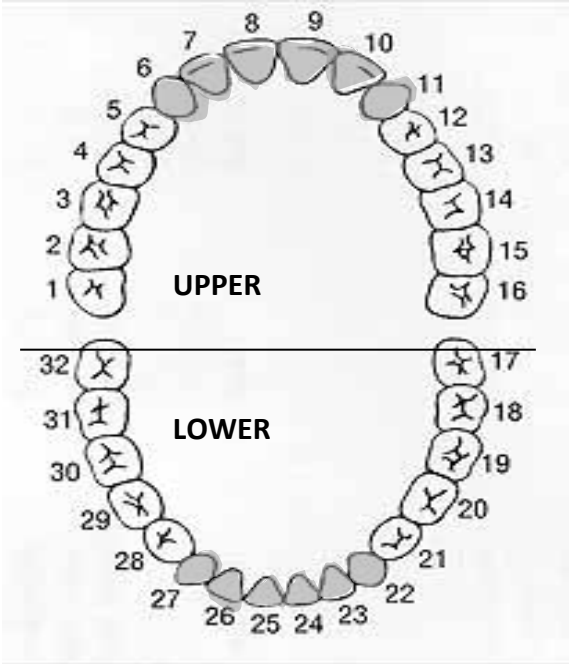
a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Dental records from the provider, if applicable
g. Reason for the appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 9.2.

SECTION 14. TOOTH CHART

THE PERMANENT ARCH

R I G H T



L E F T

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)

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, 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:

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

Scott White coordinates our nondiscrimination work:

Scott White,
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.

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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۔ پر کال کریں 1-877-605-3229 (TTY: 711)

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 គឺមានផ្តល់ជូនលោកអ្នក។ 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)

For help, call us directly at 888-447-8194
(En español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240