DELTA DENTAL®

2024

Oregon Group Dental Plan

Public Employees Benefit Board
Delta Dental PPO Plan
Effective date: January 1, 2024
Group number: 10002802

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

pebb
Public Employees' Benefit Board

TABLE OF CONTENTS

SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON 1

SECTION 2. MEMBER RESOURCES 2

2.1 CONTACT INFORMATION 2
2.2 MEMBER ID CARD 2
2.3 NETWORK 2
2.4 OTHER RESOURCES 2

SECTION 3. USING THE PLAN 3

3.1 NETWORK INFORMATION 3
3.1.1 In-Network Delta Dental Dentists 3
3.1.2 Out-of-Network Dentists 3
3.2 PREDETERMINATION OF BENEFITS 4

SECTION 4. BENEFIT SUMMARY 5

4.1 PAYMENT BASED ON ACTUAL FEES 5

SECTION 5. BENEFITS AND LIMITATIONS 6

5.1 DIAGNOSTIC AND PREVENTIVE SERVICES 7
5.1.1 Diagnostic 7
5.1.2 Preventive 7
5.2 BASIC SERVICES 8
5.2.1 Restorative 8
5.2.2 Oral Surgery 8
5.2.3 Endodontic 9
5.2.4 Periodontic 9
5.2.5 Anesthesia 9
5.3 MAJOR SERVICES. 10
5.3.1 Restorative 10
5.3.2 Prosthodontic 10
5.3.3 Other 11
5.4 GENERAL LIMITATION – OPTIONAL SERVICES 12

SECTION 6. HEALTH THROUGH ORAL WELLNESS 13

6.1 HOW TO FIND A DENTIST REGISTERED WITH THE HEALTH THROUGH ORAL WELLNESS PROGRAM 13
6.2 CLINICAL RISK ASSESSMENT 13
6.2.1 Tooth Decay Risk Assessment 13
6.2.2 Gum Disease Risk Assessment 13
6.2.3 Oral Cancer Risk Assessment 14
6.3 ENHANCED BENEFITS 14
6.3.1 Tooth Decay and Gum Disease Enhanced Benefits 14

6.3.2 Oral Cancer Enhanced Benefits 14
6.3.3 Limitations 14
6.4 When Enhanced Benefits End 14
SECTION 7. EXCLUSIONS 15
SECTION 8. ELIGIBILITY 19
SECTION 9. CLAIMS ADMINISTRATION & PAYMENT 20
9.1 Submission and Payment of Claims 20
9.1.1 Explanation of Benefits (EOB) 20
9.1.2 Claim Inquiries 20
9.2 Appeals 20
9.2.1 Time Limit for Submitting Appeals 20
9.2.2 The Review Process 20
9.2.3 Definitions 21
9.3 Benefits Available from Other Sources 21
9.3.1 Coordination of Benefits (COB) 21
9.3.2 Third Party Liability 23
9.3.3 Motor Vehicle Accident Recovery 25
SECTION 10. CONTINUATION OF DENTAL COVERAGE 26
10.1 COBRA Continuation Coverage 26
10.1.1 Address Changes 28
10.1.2 Questions 28
SECTION 11. PROTECTED HEALTH INFORMATION 29
SECTION 12. DEFINITIONS 30
SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES 34
13.1 Miscellaneous Provisions 34
SECTION 14. TOOTH CHART 37
SECTION 15. NONDISCRIMINATION 38

SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON

This handbook describes the main features of the Public Employees' Benefit Board (the Group) dental plan (the "Plan").

The Plan is self-funded by the Group and has contracted Delta Dental Plan of Oregon (abbreviated as Delta Dental) 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.modahealth.com/pebb. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

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.

The Group may change or replace this handbook 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.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to your **Member Dashboard**)
www.modahealth.com/pebb
Includes many helpful features, such as Find Care (use to find a participating dentist)

Members with both Moda Health Medical and Delta Dental Plans (Health Navigators)
Toll-free 844-827-7100

Dental only Customer Service Department
Toll-free 844-827-7100
En español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Public Employee's Benefit Board (PEBB)
503-373-1102

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 will 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 network
Delta Dental PPO Network

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. For questions about eligibility and enrollment, you should contact the Public Employees' Benefit Board at 503-373-1102 or inquiries.pebb@state.or.us.

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

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

3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. In-network Delta Dental PPO dentists contract to provide dental care to members. By using an in-network Delta Dental PPO dentist, covered dental expenses will be paid at a higher rate. If you choose an in-network dentist from the Delta Dental PPO Directory (available on your Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. For members outside Oregon, Delta Dental national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

If you need dental care, you may go to any dental office. However, there are differences in reimbursement by Delta Dental for in-network Delta Dental PPO dentists and out-of-network dentists. Out-of-network dentists include participating Delta Dental Premier (contracted with the Delta Dental Premier network) and non-participating dentists (not contracted with Delta Dental). While you may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

3.1.1 In-Network Delta Dental Dentists

Covered dental expenses will be paid at the in-network rate if you use an in-network Delta Dental PPO dentist. Payment to in-network Delta Dental PPO dentists will be the lesser of the PPO Fee Schedule amount and the dentist's actual billed fees. The dentist may not charge you the difference between the PPO fee schedule amount and the billed charge for covered services.

3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist participating in the Delta Dental Premier network will be paid at the out-of-network rate and will be based on the dentist's filed or contracted fee with Delta Dental or fees actually charged, whichever is less. The dentist may not charge the member the difference between the filed fee and the billed charge.

Payment to an out-of-network dentist not participating in a Delta Dental network will be paid at the out-of-network rate and will be limited to the amount in the PPO Fee Schedule. The allowable fee for providers in states other than Oregon will be that state's Delta Affiliate's non-participating

dentist allowance. You may have to pay the difference between the PPO Fee Schedule 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.

SECTION 4. BENEFIT SUMMARY

Calendar year maximum	$1,750
Calendar year deductible per member	$ 50
Calendar year deductible entire family	$ 150

Service	In-network Benefits	Out-of-network Benefits
Diagnostic & Preventive - Deductible waived Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	**100%**	**90%**
Basic - Deductible applies Restorative Dentistry Oral Surgery Endodontics Periodontics	**1st year -80%** **2nd year-90%** **3rd year-100%**	**70%**
Major - Deductible applies Bridges Dentures Crowns Cast Restoration Implants Athletic Mouthguards	**50%**	**50%**
Orthodontic Benefit - $1,800 Lifetime Maximum	**50%**	**50%**

4.1 PAYMENT BASED ON ACTUAL FEES

The benefit amounts for various services are listed above. The percentages are applied to the actual fees of the participating Delta Dental Premier dentists. THESE FEES HAVE PREVIOUSLY BEEN FILED WITH, AND APPROVED BY Delta Dental. THE DENTIST MAY NOT CHARGE YOU MORE THAN THEIR FILED FEES.

SECTION 5. BENEFITS AND LIMITATIONS

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. 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 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 7 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 calendar year (January 1 through December 31). Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

Deductible: $50
Per member (not to exceed $150 per family) per year, or portion thereof.
Deductible applies to covered Basic and Major services.

Maximum payment limit: $1,750
Per member per year, or portion thereof.
Covered Diagnostic, Preventive and Orthodontic services do not apply to maximum payment limit.
Members are responsible for expenses that exceed the annual maximum plan payment limit.

For **In-network** benefits, a member must receive care from a dentist from the Delta Dental PPO (PPO Provider) Directory. Each family member may choose a different PPO dentist. If care is received from a dentist not in the Delta Dental PPO Network, Out-of-Network coverage levels apply. Coverage levels are shown below:

5.1 DIAGNOSTIC AND PREVENTIVE SERVICES
COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE FOR IN-NETWORK BENEFITS AND 90% FOR OUT-OF-NETWORK BENEFITS.

5.1.1 Diagnostic

a. Diagnostic Services:

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

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive examinations (including problem focused comprehensive examinations) or consultations are covered twice per year.
ii. Limited examinations or re-evaluations are covered twice per year
iii. Complete series x-rays or a panoramic film is covered once in any 5-year period. This time period is calculated from the previous date of service.
iv. Supplementary bitewing x-rays are covered once per year for children under 15 years of age and once in a 2-year period for members age 15 years of age and older.
v. You may qualify for a higher x-ray frequency based on the dentist's assessment of your oral health and risk factors. (The maximum frequency, available only by dentist assessment, is bitewings twice per year; complete series or panoramic once in a 3-year period.)
vi. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
vii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.

5.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Space maintainers
v. Sealants

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year unless the dentist's assessment of your oral health and risk factors indicates the need for more frequent cleanings. (The maximum frequency, available only by dentist assessment, is four cleanings per year.) Refer to section 5.2.4, Periodontal benefits, for frequency and limitations on periodontal maintenance.
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered twice per year if you are age 18 and under. If you are age 19 and over, topical application of fluoride is covered twice per year if you have a recent history of periodontal surgery or a high risk of decay because of medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene is not a medical disease).

iv. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
v. Space maintainers are a benefit once per quadrant per lifetime. Space maintainers for primary anterior teeth, missing permanent teeth or if you are age 19 and over are not covered.

5.2 BASIC SERVICES

COVERED SERVICES PAID AT 80% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST YEAR A MEMBER IS ELIGIBLE FOR IN-NETWORK BENEFITS.

Payment increases by 10% each successive year. To qualify for this 10% increase, you must visit an in-network Delta Dental PPO network dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment never drops below 80%.

COVERED SERVICES PAID AT 70% FOR OUT-OF-NETWORK BENEFITS. (THERE IS NO 10% INCREASE PROVISION).

5.2.1 Restorative

a. Restorative Services:
i. Amalgam fillings and composite fillings to treat decay
ii. Stainless steel crowns

b. Restorative Limitations:
i. Inlays are considered an optional service. We will pay an alternate benefit of a composite filling.
ii. Crown buildups are included in the crown restoration cost. A buildup is covered only if necessary for tooth retention.
iii. 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.
iv. 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.
v. See section 5.3.1 for additional limitations when teeth are restored with crowns or other cast restorations.

5.2.2 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 removal of teeth is not covered.
ii. Surgery on larger lesions 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. Brush biopsy is covered twice in a 12-month period. Benefits are limited to sample collection. Pathology (lab) services are not covered.

5.2.3 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. Pulp capping is covered only when there is exposure to the pulp.
iv. Cost of retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.
v. A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.

5.2.4 Periodontic

a. Periodontic Services:

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
ii. Periodontal maintenance is not covered unless the dentist's assessment of your oral health and risk factors indicates the need. (The highest frequency, available only by dentist assessment, is four prophylaxis and/or periodontal maintenance, per year.)
iii. A separate charge for post-operative care done within 3 months after periodontal surgery is not covered.
iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
v. 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.
vi. Full mouth debridement is limited to once in a 2-year period. If you are 19 or older, it is not is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2 years.

5.2.5 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

5.3 MAJOR SERVICES.

COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE FOR IN-NETWORK BENEFITS AND 50% FOR OUT-OF-NETWORK BENEFITS

5.3.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 5.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. We will pay for a gold restoration, and you will have to pay the difference.
iii. If your tooth can be restored with a material such as amalgam or composite, but you or your dentist choose another type of restoration, the covered expense is limited to the cost of composite. Crowns are only covered if the tooth cannot be restored by a routine filling.
iv. A separate, additional charge to repair a restoration done within 2 years of the original restoration is not covered.

5.3.2 Prosthodontic

a. Prosthodontic Services:

i. Bridges
ii. Partial and complete dentures
iii. Denture relines
iv. Repair of an existing prosthetic device
v. Implants and implant maintenance
vi. Surgical stent in conjunction with a covered surgical procedure

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 for missing anterior permanent teeth of 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, repairs, and relines*:* A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines and repairs 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 36-month period.

vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years. The Plan will also cover:
    A. The final crown and abutment over a single implant. These benefits are limited to once per tooth or tooth space in any 7-year period; or
    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. The benefit is limited to once per tooth or tooth space in any 7-year period.
    D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
    E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

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

ix. 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.

5.3.3 Other

a. Other Services:

i. Athletic mouthguard
ii. Nightguard (Occlusal guard)
iii. Nitrous oxide
iv. Orthodontia to correct malocclusioned teeth, including placement of a device to facilitate eruption of an impacted tooth. You must be examined in-person to establish necessity

b. Other Limitations:

i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under 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.

ii. A nightguard (occlusal guard) is covered once every 5 years at 100% up to $150 maximum with no deductible. Repair or reline and adjustment of occlusal guard is covered once every 12-month period. Over-the-counter nightguards are not covered.

iii. Nitrous oxide is covered in conjunction with a covered dental procedure done in a dental office. There is a 12-month exclusion period for this benefit.

iv. Lifetime maximum of $1,800 per member for orthodontic services. This maximum is not included in the annual maximum payment limit. Any deductible is waived.
v. Pre-orthodontic treatment exam is part of the comprehensive orthodontic treatment plan.
vi. Self-administered orthodontics are not covered.
vii. Payment for orthodontia will end when treatment stops for any reason before completion, or when your eligibility ends. If treatment began before you were eligible under the Plan, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.
viii. A separate charge for a retainer or the repair or replacement of an appliance furnished under the Plan is not covered.

5.4 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. You will have to pay the rest of the dentist's fee.

SECTION 6. HEALTH THROUGH ORAL WELLNESS

Our Health through Oral Wellness program offers enhanced benefits, 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 modahealth.com/pebb 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 at 888-217-2365 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 keep your eligibility. You will qualify for enhanced benefits regardless of your tooth decay risk score 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 gum disease risk score 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 keep your eligibility. 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. Prophylaxis (cleaning) or periodontal maintenance 4 times per year,
b. Fluoride varnish or topical fluoride 4 times per year,
c. Sealants on the unrestored occlusal surfaces of permanent molars once per tooth every 3 years,
d. Oral hygiene instruction or nutritional counseling once in any 12-month period, and
e. Drugs or medicaments dispensed in the office for home use once in any 6-month period.

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.

Enhanced benefits may not be combined with any additional prophylaxis and periodontal maintenance services based on a dentist's assessment of your oral health and risk factors as described in sections 5.1.2 and 5.2.4.

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 (described in section 5) 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. 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, if they relate to a condition that is otherwise covered, or if 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 5.2.5

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

Behavior Management
Substances used for the purpose of pain relief

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
Administrative office processes, including translation and sign language services

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 except for emergency care

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 you are in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions Counseling or Training
Including tobacco cessation counseling, plaque control, oral hygiene or dietary instruction and tobacco cessation counseling, except as provided through the Health through Oral Wellness program (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 5.3.2

Medications
Except as allowed under Health through Oral Wellness program (section 6)

Missed Appointment Charges

Never Events
Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to 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 occlusal or athletic mouthguards as provided in section 5.3.3. 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

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 under 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

Taxes
A separate charge for 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)

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 carrier.

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 8. ELIGIBILITY

The Public Employees' Benefit Board (PEBB) eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. You should refer to the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

SPECIAL RULES REGARDING ENROLLMENT IN THE DENTAL PLAN

8.1 Employees and eligible family members have the option to enroll in the dental plan. The employee and/or family members enrolled in the dental plan do not have to match the employee and/or family members enrolled in the medical plan. Employees may enroll family members within 30 days of a qualified midyear change event. The qualifying change event and the requested enrollment must be consistent under IRS rules.

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 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). The Explanation of Benefits will indicate if a claim has been paid, denied, or accumulated toward satisfying the 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.

9.1.2 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. The Plan will respond to your inquiry within 30 days.

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

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 send you a letter no more than 7 days after we receive your appeal so you know we got it
c. Someone who was not involved in the original decision will investigate your appeal
d. 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 5 or section 7, 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, and 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 all 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 healthcare 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 the Plan is the primary plan**,** the Plan will pay benefits as if there was not any other coverage.

If the Plan is 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 the Plan 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 coverage
c. We will reduce the benefits paid by the Plan 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 because you did not follow that plan's rules, the Plan will not cover that expense either.

If the primary plan is a closed panel plan (HMO is an example) and you use an out-of-network provider, the Plan will provide benefits as if it is 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 that 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, and surrogacy, 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, a company or an insurer. Recovery from a third party may be difficult and take a long time, so the Plan will pay your covered expenses based on the understanding and

agreement that the Plan is entitled to be reimbursed for any benefits it 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 actions that will help us recover costs from a third party. The Plan has discretion to interpret these recovery and subrogation provisions.

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

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 to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by the Plan.

g. If you or your representatives do not comply with the requirements of this section, then the Plan 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 9.3.3). We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

9.3.3 Motor Vehicle Accident Recovery

If you file a claim with us for dental expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, then the Plan will advance benefits. The Plan retains 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 the Plan requires you or your attorney to protect its recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

SECTION 10. CONTINUATION OF DENTAL COVERAGE

Continuation of coverage under the PEBB program is governed under Chapter 101, Division 30 of the Oregon Administrative Rules. The following is a summary of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). There may be additional continuation options available; employees should refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

10.1 COBRA CONTINUATION COVERAGE

COBRA continuation is administered by a COBRA Administrator. The Plan Sponsor, the Public Employees' Benefit Board (PEBB) is located at 1225 Ferry Street SE in Salem, Oregon or at (503) 373-1102 or 1-800-788-0520 for more information.

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

If you are the spouse or a 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 for gross misconduct) or their hours of employment with the Group are reduced
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare
e. 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 (such as 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.

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/domestic partner 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 first day of the month. You will not receive a bill. You are responsible for paying your premiums when due. 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.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months.

COBRA because of a subscriber's death, divorce or legal separation, termination of a 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 of the end of employment or reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may 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, or a child 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.

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 end if:

a. you become covered under another group dental plan (this does not apply to CHAMPUS or Tri-Care)
b. you become entitled to Medicare benefits after electing COBRA.
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.

10.1.1 Address Changes
PEBB needs to be informed of any changes in the addresses of family members. Members should also keep a copy in their records, of any notices sent to PEBB.

10.1.2 Questions
This notice is simply a summary of potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of the COBRA rights at that time. If you do not understand any part of this summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at:

503-373-1102
inquiries.pebb@state.or.us
http://pebb.das.state.or.us

The nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

SECTION 11. PROTECTED HEALTH INFORMATION

Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Delta Dental may disclose de-identified summary health information to PEBB for purposes of modifying, amending or terminating this Plan. In addition, Delta Dental may disclose protected health information (PHI) to PEBB in accordance with the following provisions of this Plan as established by PEBB:

a. PEBB may use and disclose the PHI it receives only for the following purposes:
    i. Administration of the Plan; and
    ii. Any use or disclosure as required by law.
b. PEBB shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to PEBB with respect to such information.
c. PEBB shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of PEBB.
d. PEBB shall report to Delta Dental any use or disclosure of PHI that is inconsistent with the provisions of this section of which the PEBB becomes aware.
e. PEBB shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.
f. PEBB shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.
g. PEBB shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.
h. PEBB shall make its internal practices, books and records relating to the use and disclosure of PHI received from Delta Dental available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
i. PEBB shall, if feasible, return or destroy all PHI received from Delta Dental and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. PEBB shall provide for adequate separation between PEBB and Delta Dental with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of PEBB or designated individuals:
    i. Benefit Manager;
    ii. Director of Operations;
    iii. PEBB's Designated Consultants; and
    iv. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

Further, PEBB shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for PEBB with regard to this Plan. In addition, PEBB shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

SECTION 12. DEFINITIONS

Abutment is a connection device that attaches a restoration to the root form implant.

Affidavit of Domestic Partnership is a signed document that attests that you and one other eligible person meet the criteria in the affidavit to be unregistered domestic partners.

Alveoloplasty is the surgical 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 placement of a full or partial denture.

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

Anterior refers to teeth 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 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.

Calendar Year means a period beginning January 1st and ending December 31st.

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 you get a covered service. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for non-participating providers or the cost of non-covered services.

Covered Service is a service or supply 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 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. A reference to Delta Dental as paying claims or

issuing benefits means that Delta Dental processes the claim and the Group reimburses Delta Dental for any benefit issued.

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

a. Are established as necessary to treat or 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 and/or
d. Are the least costly of the alternative supplies or levels of service that can be safely provided. For example, benefits would not be issued for a crown when a filling would restore the tooth appropriately

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

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

Denture Repair is a procedure 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. **Registered Domestic Partner** is a person of the same sex joined with the subscriber in a partnership that has been registered under the Oregon Family Fairness Act.
b. **Unregistered Domestic Partner** is a person who has entered into a partnership with the subscriber that meets the criteria in the Domestic Partner Affidavit on file with PEBB.

Eligible Employee for the purpose of this handbook, is an employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan.

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.

Exclusion Period is a period of time during which specified treatments or services are excluded from coverage.

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

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

Implant is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jawbone 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 means a licensed dentist who contracts in the preferred provider network (PPO) to provide dental care to members.

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

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For an in-network Delta Dental PPO dentist and for non-participating dentists or dental care providers, the maximum amount is based on the PPO fee schedule. For a dentist participating only on the Premier Plan, the maximum amount is the dentist's filed or contracted fee with Delta Dental. When using a non-participating dentist or dental care provider, any amount above the MPA is your responsibility.

Member is the subscriber, dependent of the subscriber or a person otherwise eligible for the Plan 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.

Non-participating Dentist or Dental Provider is a licensed dental provider who has not contracted to be part of the Delta Dental PPO network or the Delta Dental Premier network.

Out-of-Network Dentist or Dental Provider is a licensed dental provider who has not contracted as an in-network Delta Dental PPO dentist.

Participating Delta Dental Premier Dentist is a licensed dentist who has agreed to provide services in the Premier network in accordance with Delta Dental's terms and conditions and has satisfied Delta Dental that they are complying with such terms and conditions.

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 and Delta Dental is contracted to provide claims and other administrative services.

Plan Sponsor means the Group.

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

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

PPO Fee Schedule is the amount negotiated between Delta Dental and a 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 created in the dentist's office. A **laboratory veneer** 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 the Plan. PHI includes enrollment, claims, and medical and dental information. This information is used to pay your claims. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how the Group uses your PHI. Delta Dental, as the claims administrator, is required to adhere to these same practices. Members can contact the Group if they have additional questions about the privacy of their information beyond what is provided in the Notice of Privacy Practices.

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

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 Care
You always have the right to choose your dental provider. Neither the Plan nor Delta Dental is responsible for the quality of your care. Delta Dental and participating dentists are independent contractors. The dentist is solely responsible for the dental care provided to you. Delta Dental does not control the detail, manner or methods by which a participating dentist provides care. Neither the Plan nor Delta Dental can be held liable for the negligence of any dentist providing services to you.

Provider Reimbursement
Under state law, 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 member 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.

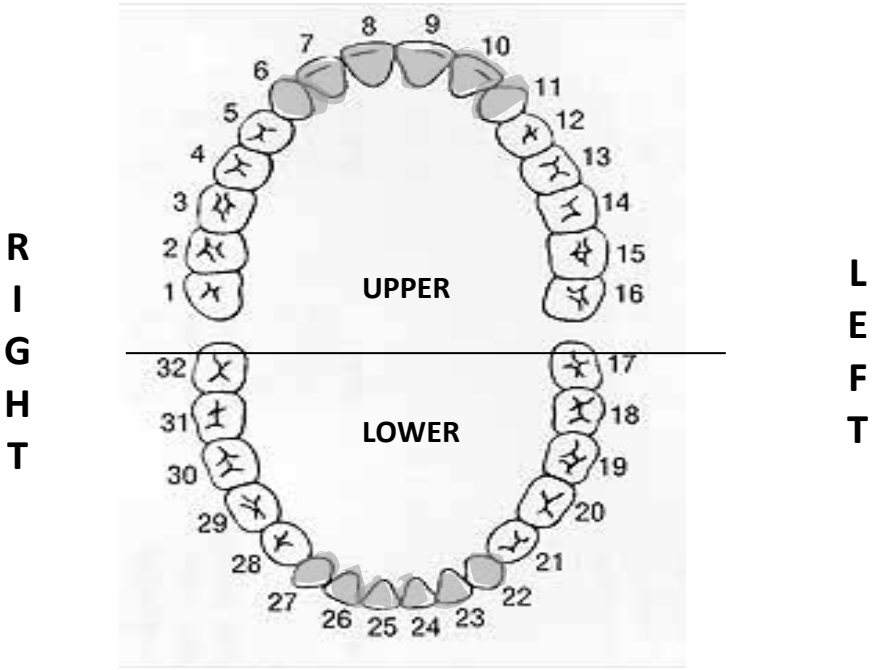
Time Limit for Filing a Lawsuit
Any legal action arising out of, or related to, the Plan and filed against Delta Dental or the Plan by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 9.1). All internal levels of appeal under the 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.

SECTION 14. TOOTH CHART

THE PERMANENT ARCH



Anterior teeth are shaded gray.

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

Nondiscrimination notice

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

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

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

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

888-217-2365 (TDD/TTY 711)

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

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

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

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

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

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

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

DELTA DENTAL®

Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

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

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

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

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

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

For help, call us directly at 844-827-7100.
(En español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240