DELTA DENTAL®

2024

Oregon Group Dental Plan

Public Employees Retirement System
Delta Dental PPO Plan Preventive First
Effective Date: January 1, 2024
Group Number: 10004761

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

Dental plans in Oregon provided by Delta Dental of Oregon.

TABLE OF CONTENTS

SECTION 1. WELCOME

Delta Dental Plan of Oregon (abbreviated as Delta Dental) was created in 1955 and is a founding member of the Delta Dental Plans Association. Delta Dental Plan of Oregon is the state's largest dental insurer, offering coverage in the commercial market and administering the Oregon Health Plan.

We are pleased your Group has chosen Delta Dental as its dental plan. This handbook will give you important information about the Plan's benefits, limitations and procedures.

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/pers. 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, by the Group or Delta Dental, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's policy 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.modahealth.com/pers
Includes many helpful features, such as Find Care (use to find an in-network dentist)

Dental Customer Service Department
Toll-free 844-827-7379

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 network
Delta Dental Premier
Delta Dental PPO

2.4 OTHER RESOURCES

You can find other general information about the Plan in section 12.

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 through 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 for Delta Dental PPO dentists, Delta Dental Premier dentists and out-of-network dentists. 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 or 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 amount in the PPO Fee Schedule. 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. BENEFITS AND LIMITATIONS

Below is a general list of services 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 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: $25
Per member per year, or portion thereof
Deductible applies to covered Class II and Class III services

Annual maximum plan payment limit:
$1,750 per member per calendar year, or portion thereof
All covered services except class I apply to the annual maximum plan payment limit.
Members are responsible for expenses that exceed the annual maximum plan payment limit.

Waiting Period: Benefits are not available for oral surgery, restorative, endodontic, periodontic, and prosthodontic services under Class II and Class III services for the first 12 months following your effective date of coverage.

The waiting period will be waived if you had 12 months of continuous dental coverage.

The waiting period does not apply to medicaments covered under the Health through Oral Wellness program if you qualify for this benefit.

4.1 CLASS I
COVERED SERVICES PAID AT 100%

4.1.1 Diagnostic

a. Diagnostic Services:

i. Exam
ii. Intra-oral x-rays to assist in determining required dental treatment

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive exams (including problem focused comprehensive exams) or consultations are covered twice per year
ii. Limited exams 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
iv. Supplementary bitewing x-rays are covered once per year
v. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
vi. Only these x-rays are covered: complete series or panoramic, periapical, occlusal and bitewing

4.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see section 5).
iii. Periodontal maintenance
iv. Topical application of fluoride
v. Sealants
vi. Space maintainers

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year. Additional periodontal maintenance is covered if you have periodontal disease, up to a total of 2 additional periodontal maintenances per year.
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 twice per year if you are under age 19. 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 high risk of decay because of medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
iv. Sealants are only covered on the unrestored occlusal surfaces of permanent molars. Benefits are limited to one sealant per tooth during any 5-year period.
v. Space maintainers are covered once per space 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%

4.2.1 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 an amalgam filling.
ii. Fillings on anterior or posterior teeth are limited to once per tooth every 24-months
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 a 2-year period 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 removal of teeth is not covered.
ii. Surgery on malignant lesions is not considered minor surgery.

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.

4.2.4 Periodontic

a. Periodontic Services:

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

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
ii. Periodontal maintenance is covered under Class I, Preventive.
iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
iv. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
v. Full mouth debridement is limited to once in a 2-year period and, if you are age 19 or older, it is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2-years.

4.2.5 Anesthesia

a. General anesthesia or IV sedation

Covered only:

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

4.3 CLASS III
COVERED SERVICES PAID AT 50%

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.
ii. Stainless steel crowns

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See 4.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you must pay the difference.
iii. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.
iv. 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. 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 will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only covered to replace missing anterior permanent teeth for age 16 or under when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. 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 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. 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. 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.
viii. Fixed bridges or removable cast partial dentures are not covered if you are under age 16.

4.3.3 Other

a. Other Services:

i. Athletic mouthguard

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 for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.
ii. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

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 treatment. You will then have to pay the rest of the dentist's fee.

SECTION 5. ORAL HEALTH, TOTAL HEALTH BENEFITS

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

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

Delta Dental has developed a program that provides additional cleanings (prophylaxis or periodontal maintenance) for Delta Dental members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 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 blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

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

5.1.2 Pregnancy

Keeping the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, 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 regardless of when you had a previous cleaning.

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 PROGRAM

Delta Dental's 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 www.modahealth.com/pers and select Find Care.

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

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

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

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 in order 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 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 once every 3 months,
b. Fluoride varnish or topical fluoride once every 3 months,
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.

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, eligibility for enhanced benefits will end. 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. 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, nitrous oxide, 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

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

Congenital or Developmental Malformations
Includes but not limited to 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
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

Experimental or Investigational Procedures
Including expenses related to or needed because of such procedures

Facility Fees
Including additional fees charged by the dentist for hospital, state approved community health and developmental disabilities program, extended care facility or home care treatment

Foreign Care
Non-emergent care provided outside the United States is excluded

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

Hypnosis

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

Inmates
Services and supplies 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 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 for surgical stents as stated in section 4.3.2

Medications
Except as allowed under Health Through Oral Wellness as seen in section 6

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.

Orthodontia

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 athletic mouthguards as provided in section 4.3.3. Excluded services include increasing vertical dimension, equilibration, occlusal guards 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 employer's liability laws
b. Any city, county, state or federal law, except for Medicaid coverage
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 and are considered parts of the same plan

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 8.3.2)

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 are 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 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. CLAIMS ADMINISTRATION & PAYMENT

8.1 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.

8.1.1 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, the reason will be stated in the EOB. We encourage you to access your EOBs electronically by signing up through the 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 8.1.

8.1.2 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. We will respond to your inquiry within 30 days.

8.1.3 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 8.1.

8.2 APPEALS

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

8.2.1 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

8.2.2 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, call Customer Service. You may review the claim file and submit evidence as part of the appeal process, and may appoint a representative to act on your behalf
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

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

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

8.2.3 Definitions

For purposes of section 8.2, 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 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

8.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

8.3.1 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.

8.3.1.1 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
    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.

8.3.1.2 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 because 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.

8.3.1.3 Definitions

For purposes of section 8.3.1, 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

8.3.2 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 we are 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 our right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. We are 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 our subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect our 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 us.

b. We are 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. We are 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 we require you and your attorney to protect our 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 8.3.2.
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 8.3.2 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 8.3.2.1). We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

8.3.2.1 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. We have 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 our 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 9. ELIGIBILITY & ENROLLMENT

You are eligible for this dental care program in accordance with the eligibility requirements of PHIP. You must reside in the United States and be enrolled in one of the PERS sponsored medical plans currently available.

9.1 ELIGIBLE PERSONS

You are eligible to enroll in the Plan if you:

a. Are a PERS retiree and/or spouse, dependent or dependent domestic partner of a PERS retiree; or
b. are an eligible surviving spouse, dependent or dependent domestic partner of a deceased PERS retiree; or
c. Are an eligible surviving spouse, dependent or dependent domestic partner of a deceased PERS member who was not retired but who was eligible to retire at the time of death.

9.2 ENROLLING ELIGIBLE PERSONS

9.2.1 New Retiree

If you are a new retiree, you and your eligible spouse, dependent domestic partner or dependent children may enroll by completing an enrollment request form and submitting it to the Group within 90 days of the effective date of your PERS retirement, within 90 days of the date of the Notice of Award letter issued by the Social Security Administration or within 90 days of the date of the Disability Approval Letter, if you receive retroactive eligibility for disability retirement. Coverage will begin on the PERS retirement effective date if applying before the retirement date or on the first day of the month following receipt of the completed enrollment request form if applying after the retirement date.

9.2.2 Medicare Eligibility

You or your eligible spouse, dependent domestic partner or dependent children may enroll by filling out an enrollment request form and submitting it to the Group within 90 days of the date of initial Medicare eligibility if enrolled in both Part A and Part B. If you receive retroactive eligibility for Medicare as a result of an appeal to an initial denial for eligibility, the enrollment form must be submitted within 90 days from the date you are notified of your enrollment in Medicare. Coverage will begin on the date Medicare coverage becomes effective if applying before the date of Medicare eligibility and on the first day of the month following receipt of the enrollment form if applying after the date of Medicare eligibility.

Coverage will begin on the first of the month following the later of the following dates:

a. The date retirement becomes effective, if written request for coverage is made before such date.
b. Receipt of the application, if the request is made within 90 days from PERS retirement effective date or initial Medicare eligibility.
c. The Group's acceptance of the application for coverage.

Coverage for new dependents due to marriage or dependent domestic partnership will begin the first of the month following the date the enrollment application is received in the PERS PHIP office, provided the application is made within 30 days of the date the person becomes your dependent.

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

9.3 DEPENDENT DOMESTIC PARTNERS

Dependent Domestic Partner means an individual who has a relationship with you that has the characteristics described below. You and dependent domestic partner must:

a. share a close personal relationship and be responsible for each other's common welfare, including but not limited to having joint financial responsibilities
b. be each other's sole domestic partner
c. not be married to anyone, nor have had another domestic partner within the previous 12 months
d. not be related by blood so closely as to bar marriage in the State of Oregon
e. have jointly shared the same regular and permanent residence for at least 12 months immediately preceding the effective date of coverage with the intent to continue doing so indefinitely
f. have the PERS retiree providing over one half of the financial support for the person and qualify as a dependent of the PERS retiree as determined under section 105(b) of the Internal Revenue Code, 26 USC 105(b), as amended by the Working Families Tax Relief Act of 2004, P.L. 108-311.

9.4 DEPENDENT CHILDREN

Your children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26. Legal custody or guardianship does not apply.

For purposes of determining eligibility, the following are considered children under OAR 459-035-0001:

a. A natural child;
b. A legally adopted child or a child placed in the home pending adoption;
c. A step-child who resides in the household of the stepparent who is an eligible retired member;
d. A grandchild, provided that at the time of birth, at least one of the grandchild's parents was covered under a PERS-sponsored health insurance plan as a dependent child of the PERS member or retiree and resides in the household of the member or retiree.

When a new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage begins on the first day

of the month after the date the PERS office determines that the order qualifies as a QMCSO, and that the child is eligible to enroll in the Plan.

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 overage coverage under the medical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, the subscriber must submit 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.

9.4.1 New Dependents
A new spouse, dependent domestic partner, or dependent child as defined in OAR 459-035-0001, must enroll within 30 days of becoming a spouse, dependent domestic partner or dependent child.

9.5 WHEN COVERAGE ENDS

The circumstances in which your coverage will end are described in the following sections. When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

9.5.1 The Group Plan Ends
If the Plan is terminated for any reason, coverage ends for the Group as a whole and members on the date the Plan ends.

9.5.2 Subscriber Ends Coverage
You may end your coverage, or coverage for any enrolled dependent, by giving Delta Dental written notice through the Group. Coverage ends on the last day of the month through which premiums are paid.

9.5.3 Subscriber's Death
a. Your eligible surviving spouse, dependent domestic partner or dependent child who is enrolled in the Plan may continue coverage under that plan according to OAR 459-035-0070 (1)(d).
b. Your eligible surviving spouse, dependent domestic partner or dependent child who is not covered at the time of the your death may enroll according to OAR 459-035-0070 (1)(e)

    i. within 90 days of the death
    ii. within 30 days of the loss of other group coverage that was in effect for 24 consecutive months immediately preceding enrollment
    iii. within 90 days of initial Medicare eligibility, if enrolled in Parts A and B of Medicare

9.5.4 Loss of Eligibility by Dependent
Coverage ends

a. For an enrolled spouse on the date the spouse becomes eligible as a retiree or surviving dependent under the Plan or on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal).

b. For an enrolled dependent domestic partner on the date the domestic partner becomes eligible as a retiree or surviving dependent under the Plan or on the last day of the month in which the domestic partnership no longer meets the requirements of the Declaration of Domestic Partnership filed with the Group.
c. For an enrolled child on the last day of the month in which
   i. they turn age 26
   ii. stepchild relationship ends due to divorce or end of domestic partnership
   iii. legal guardianship ends

You must tell us when a marriage, domestic partnership or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends (see section 10).

9.5.5 Medicare Eligibility

Failure to submit a new Enrollment Request Form for Medicare coverage when becoming Medicare eligible will result in cancellation of health plan coverage, including dental coverage.

9.5.6 Rescission

Recission means canceling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group. 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
c. Submitting false or altered claims

We have the right to keep any premiums paid as liquidated damages. You and/or the Group will have to repay any benefits that have been paid. We will tell you of a rescission decision 30 days before your coverage is canceled.

9.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including, but not limited to member birth certificates, adoption paperwork, marriage or domestic partnership documents and any other evidence necessary to document your eligibility for the Plan.

SECTION 10. CONTINUATION OF DENTAL COVERAGE

Check with the PERS Health Insurance Program to find out if you qualify for continuation coverage. You should read the following sections carefully.

10.1 55+ OREGON CONTINUATION

*A dependent domestic partner enrolled under this Plan will only qualify for 55+ Oregon Continuation if they are also registered in Oregon under the Oregon Family Fairness Act ("dependent registered domestic partners").

55+ Oregon Continuation applies to employers with 20 or more employees. It provides continuation coverage for spouses and dependent domestic partners age 55 and older who is 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 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. You will be given information about how to sign up for continuation coverage and pay premiums.

If you do 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 "dependent domestic partner" refers only to a registered domestic partner, as defined in section 11.

If the Group or its third party administrator does not notify you of your continuation rights, the Group is responsible for premiums from the date the notice was required until the date you receive the notice.

10.2 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 or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. Termination of the subscriber's PERS retirement status
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
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 (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.

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. 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 a termination of PERS retirement status generally lasts up to 18 months.

COBRA because of the subscriber's death, divorce or legal separation, 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 termination of PERS retirement status, 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 PERS retirement status
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 of PERS retirement status

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 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's no longer being eligible as a dependent under the Plan. These events 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 dependent 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 10.1).

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.

***Special Circumstances**
A dependent domestic partner does not have an independent election right under COBRA. If you are a covered dependent domestic partner at the time of the qualifying event, the subscriber can include coverage for you when they elect COBRA. Your coverage ends when the subscriber's COBRA coverage ends (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

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 11. DEFINITIONS

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or 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 12).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 12).

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

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

Cast Restoration includes crowns, inlays, onlays and any other restoration to fit your tooth that is made at a laboratory or dental office and cemented into the tooth.

Coinsurance is a percentage of covered expenses that you pay.

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

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

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

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

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

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

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

Dentally Necessary means services that:

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

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

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

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

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

Dependent Domestic Partner means an individual who has a relationship with you that has the characteristics described below. You and dependent domestic partner must:

a. share a close personal relationship and be responsible for each other's common welfare, including but not limited to having joint financial responsibilities
b. be each other's sole domestic partner
c. not be married to anyone, nor have had another domestic partner within the previous 12 months
d. not be related by blood so closely as to bar marriage in the State of Oregon
e. have jointly shared the same regular and permanent residence for at least 12 months immediately preceding the effective date of coverage with the intent to continue doing so indefinitely
f. have the PERS retiree providing over one half of the financial support for the person and qualify as a dependent of the PERS retiree as determined under section 105(b) of the Internal Revenue Code, 26 USC 105(b), as amended by the Working Families Tax Relief Act of 2004, P.L. 108-311.

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

Eligible Person means any person who has met the eligibility requirements to be enrolled on the Plan (see section 9.1).

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

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

The **Group** refers to Oregon Public Employees Retirement System (PERS).

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

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

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

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

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

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

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

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

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

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

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

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

PHIP is PERS Health Insurance Program.

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

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

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

Posterior refers to teeth located toward the back of the mouth (tooth chart in section 12).

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

Subscriber means any retiree or eligible surviving dependent who is enrolled in the Plan.

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

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

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

12.1 MISCELLANEOUS PROVISIONS

Contract Provisions
The policy 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 policy 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 Notice of Privacy Practices has more detail about how we use your PHI. Following the Privacy Center link on the Delta Dental website for a copy of the notice or call 503-243-4492.

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, we have the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. Our 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 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 such services. Nothing contained in the Plan shall be construed as obligating Delta Dental to provide dental services to you.

Provider Reimbursements
Under state law, dentists contracting with Delta Dental to provide services to you agree to look only to Delta Dental for payment of the part of the expense that is covered by the Plan. They may not bill you if we fail 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 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 8.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

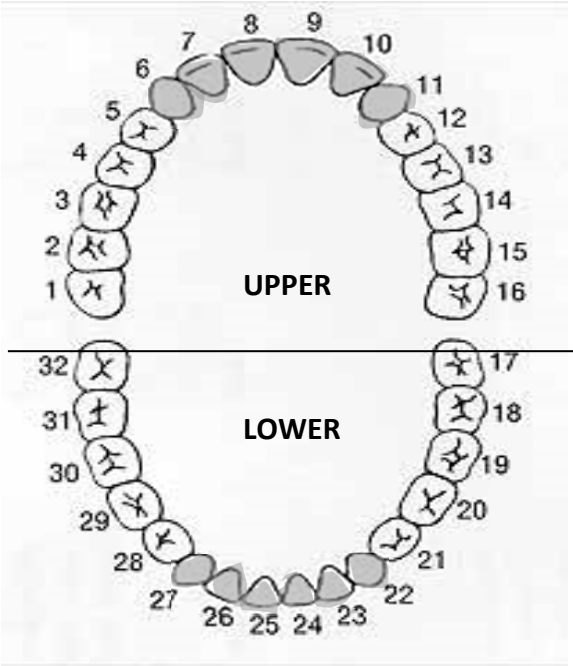
Notices

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 13. TOOTH CHART

THE PERMANENT ARCH

R I G H T



L E F T

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

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

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:

Medicare Customer Service,
800-962-1533 (TDD/TTY 711)

Pharmacy Customer Service,
888-786-7509 (TDD/TTY 711)

Dental Customer Service,
844-827-7379 (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:

Moda Health Plan, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

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.

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

modahealth.com/pers

Moda Health Plan, Inc. is a PPO and PDP with Medicare contracts. Enrollment in Moda Health Plan, Inc. depends on contract renewal.

moda HEALTH

DELTA DENTAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. 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 844-827-7379
(En español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240