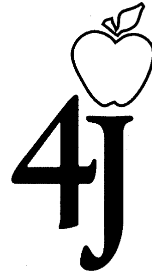

DENTAL CARE PROGRAM

Eugene Public Schools District 4J

Certified Employees

Dental No. 6602

ODS Health Plans' products provided by Oregon Dental Service.

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BENEFITS PLAN DESCRIPTION

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

Telephone Numbers

Member Inquiries

Portland (503) 948-5560
Toll Free 1-800-337-3962
TDD/TTY 1-800-433-6313
(for the hearing and speech impaired)

Dental Office Inquiries

Portland (503) 243-4494
Toll Free 1-800-452-1058

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

Welcome

Welcome to Oregon Dental Service. We hope the following information will help you get the most out of your dental benefits.

Created in 1955, ODS was the first company in America to provide prepaid dental insurance. Today we are Oregon's largest, covering over 500,000 people from more than 1,400 groups.

Our dental plans are easy to use. All of the paperwork takes place between our office and your dentist's office. And our dental plans are cost-effective. More than 90% of all licensed dentists in Oregon are ODS "participating dentists."

When you need dental care you may use any dental provider. However, there are differences in reimbursement by ODS for participating dentists and non-participating dental providers. This is explained in the "Amount of Payment" section of this booklet.

For travelers and employees outside Oregon, our 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.

Please note: This booklet is a description of your dental care program. All plan provisions are governed by the company's agreement with Oregon Dental Service. This booklet may not contain every plan provision. All provisions or terms of the policy not described in this booklet still apply.

Using Your Program

Visit the dental provider of your choice. During your first appointment, tell your dental provider that you have dental benefits through Oregon Dental Service. Give *your* identification number and ODS Group number to the dentist.

You may choose a dentist from the ODS Premier Dental Directory (which is also available on the ODS website at www.odshealthplans.com under “Dentist Search”).

You do not need to fill out claim forms, if you select a participating dentist. Your dentist will submit claims for you. You will need to sign the form, however, and provide the required patient identification information. If your dependents receive services through your dental plan, make sure that *your* identification number and Group number are listed on the treatment form.

ODS provides a pre-determination service, for any treatment plan. **We encourage you to request a pre-determination form be submitted by your dental provider, for treatment plans in excess of $500.00.** The proposed treatment will be processed according to your contract and returned to the dental provider, itemizing allowable amounts and any limitations. You and your dental provider can then review the information prior to beginning treatment and address any questions about the benefits.

If you should have any questions regarding your benefits, please do not hesitate to call the ODS dental customer service Department at 1-800-337-3962

Please Note: While an eligible person may choose the services of any dentist, Oregon Dental Service does not guarantee the availability of any particular dentist.

Definitions

For the purpose of this Policy, the following definitions shall apply:

Accepted fee means the filed fee approved by Oregon Dental Service for a specific dental procedure performed by a participating dentist submitting that fee and performing that dental service.

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

Benefits means those dental services which are available under the terms of this Policy.

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

Copayment means the relative percentages to be paid by the eligible person.

Covered employee means an employee for whom the Policyholder has made contributions to provide dental benefits.

Covered employment means employment for which an employer has made contributions to provide dental care benefits.

Dental provider means a duly licensed dentist, certified denturist or registered hygienist, legally entitled to practice dentistry at the time and in the place services are performed; to the extent that he or she is operating within the scope of his or her license, certificate, or registration as required under law within the State of practice.

Eligibility date means the date an employee's eligibility for benefits becomes effective under the terms of this Policy.

Eligible dependent means any of the dependents of an employee who are eligible for benefits in accordance with the conditions of eligibility outlined in this Policy.

Eligible employee means any employee who meets the conditions of eligibility outlined in this Policy.

Eligible person means any employee or dependent who meets the conditions of eligibility outlined in this Policy.

Group health plan means any plan, fund or program established and maintained by an employer or an employee organization, or both, for the purpose of providing health care for its participants or their beneficiaries through insurance, reimbursement or otherwise. This dental plan is a group health plan.

Maximum Plan Allowance means:

- The accepted filed fee for a participating dentist; or
- The prevailing fee for a non-participating dentist.

Medically necessary means those services and supplies that are required for diagnosis or dental treatment and which, in the judgment of ODS, are:

- Appropriate and consistent with the symptoms or diagnosis of your condition or that of your dependent;
- Appropriate with regard to standards of good dental practice in the area in which they are provided;
- Not primarily for the convenience of you, your dependents or a dentist or a dental provider of services or supplies; and
- The least costly of the alternative supplies or levels of service which can be safely provided to the insured. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a dental office without harm to the patient.

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

Non-participating dental providers means those dental providers who are not participating dentists.

Non-participating dentist means a licensed dentist who is not a participating dentist.

ODS means Oregon Dental Service, a not-for-profit dental health care service corporation.

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

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

Policy means this agreement between ODS and the Policyholder including the application of the Policyholder for this Policy and the attached appendices, amendments, endorsements and riders, if any. This Policy constitutes the entire policy between the parties.

Policyholder means the group or employer for whose members or employees dental benefits are being provided.

Policy term means the period commencing on the effective date hereof and continuing until the termination date as herein provided.

Policy year means the 12-month period commencing on the effective date and each 12-month period thereafter.

Prevailing fee in Oregon, means the fee for a single procedure which satisfied the majority (equivalent to the fifty-first (51st) percentile) of dentists in Oregon, as determined by Oregon Dental Service based upon a confidential fee listing accepted by Oregon Dental Service from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

Eligibility

EMPLOYEES

You are eligible under the Plan if you work the required number of hours as determined by your employer on a regular basis for the employer providing this coverage and you have satisfied any required probationary period. You are also eligible if you are on an approved leave of absence under the Family and Medical Leave Act of 1993.

DEPENDENTS

Your legal spouse or eligible domestic partner is eligible for insurance. Your unmarried dependent children are eligible until their 26th birthday. A child is also eligible until their 26th birthday if a court or administrative order requires you to provide health insurance.

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

- Your natural child;
- Your spouse's child, foster or adopted child;
- Children placed for adoption with you;
- Children of your eligible domestic partner;
- A Newborn child of a covered dependent for the first 31 days of the newborn's life, but only if you are financially responsible for both the newborn and the covered dependent; and
- Children related to you by blood or marriage for whom you are the legal guardian. You will need to provide a court order showing legal guardianship.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for insurance even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on you for support. The incapacity must have arisen before the child's 26th birthday. You must provide us with a written physician's statement that confirm that these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed by the ODS medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

Dependents in military service are *not* eligible.

A. Qualified Medical Child Support Order (QMCSO)

This Plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The effective date of coverage for a child added to the plan under a QMCSO is the date specified in the court order, or if none, the date of the court order.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Administrator without charge.

B. Newly Acquired Dependents

If you marry while you are insured under this Plan, your spouse and his or her children are eligible to enroll as of the date of the marriage. A completed application must be submitted within 31 days of the date of the marriage, and the effective date of the insurance will be the first of the month following receipt of the application. All children must meet eligibility requirements.

Your newborn child or your covered dependent's newborn child will automatically be insured for 31 days after birth. To continue insurance, the insured employee must submit a new application within those 31 days listing the new child as a dependent. If we do not receive the application, insurance for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

Adopted children are automatically insured for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be insured for the first 31 days from the date of placement. To extend insurance beyond the first 31 days, the insured employee must submit a new application listing the child as a dependent.

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

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children.

Enrollment

A. When You First Become Eligible

You must file an application for yourself and any dependents you want insured within 31 days of when you become eligible to apply for insurance. Employees become eligible to apply on the day you are hired or the end of any required probationary period. File the application with the Eugene Public Schools District 4J employee benefit office.

If you do not enroll yourself or any dependents you want insured within the 31-day eligibility period, you will automatically be enrolled retroactively to the appropriate effective date, however, claims will not be processed until you have submitted a completed enrollment application to the 4J employee benefit office.

Please notify 4J employee benefit office whenever you change your address.

B. Enrolling New Dependents

You may obtain insurance for newly acquired or newly eligible dependents by submitting a completed application within 31 days of their eligibility. To continue insurance for newborn children, you must submit a new dependent application before the child is 31 days old. To continue insurance for an adopted child or a child placed for adoption, you must submit a new dependent application within 31 days of adoption or placement.

The 4J employee benefit office must be notified if family members are added or dropped from coverage.

C. When Insurance Begins

Insurance coverage begins for you and any enrolled dependents on your date of hire or on your first day of active work.. There are three exceptions: newborn children are eligible to begin coverage on the date of their birth, adopted children or children placed for adoption are eligible to begin coverage on the date of adoption or placement, and court ordered coverage is effective on the date specified by the court order. The necessary premiums for your coverage must also be paid for insurance to become effective.

D. Termination of Employment

If your employment terminates, your insurance will end for you and all insured dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 27).

E. Termination By Insured Employee

You may terminate your insurance, or insurance for any insured dependent, by providing the Eugene Public Schools 4J employee benefit office with a completed and signed waiver of insurance coverage form. Insurance will end on the last day of the month through which premiums are paid. If you terminate your own insurance, insurance for your dependents also ends at the same time.

F. Loss Of Eligibility By Dependent

A covered child will lose eligibility when he or she marries, reaches age 26, is no longer dependent on the eligible employee, or when the eligible employee is no longer legally required to provide insurance for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 27).

Insurance ends for an insured spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under this Plan (see page 27).

G. Retiree Coverage

Eligible retirees may stay on this Plan as a retiree until age 65.

Important Note: The following sections on Leave of Absence and Uniformed Services Employment and Reemployment Rights Act (USERRA) may apply to you. Please check with your company's benefits manager to find out whether you qualify for this coverage.

H. Leave of Absence

If you are granted a leave of absence under the Family and Medical Leave Act of 1993, the Group may continue to provide coverage without condition during the leave and upon return from the leave, on the same basis as was provided during active employment.

I. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. However, coverage can be continued for up to 18 months or the period of uniformed service leave, whichever is shortest, if you request to continue coverage and pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the group if you are released under honorable conditions, but only if you return to active employment:

- On the first full business day following completion of your military service for a leave of 30 days or less;
- Within 14 days of completing your military service for a leave of 31 to 180 days; or
- Within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. There will be no additional eligibility waiting period and the pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer).

Amount of Payment

A. Class I Services

- The program provides **100%** toward covered Class I services.

B. Class II Services

- The program provides **80%** toward covered Class II services.

C. Class III Services

- The program provides **50%** toward covered Class III services.

D. Maximum Payment The maximum amount payable by the program for covered services received each calendar year, or portion thereof, for each eligible patient is limited to $1,500.00.

E. Deductible Class II and III covered dental services are subject to a $25.00 deductible per patient each calendar year or portion thereof.

F. Non-Participating Dental Providers

The program requires that amounts payable for services of a non-participating dental provider be limited to the applicable percentages specified in the Plan toward the prevailing fees charged by participating dentists for corresponding services. Prevailing fees in Oregon are defined as those fees which satisfy and are charged by the majority of dentists in Oregon, as determined by ODS on the basis of confidential fee listings from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

THE FOLLOWING EXAMPLE ILLUSTRATES HOW THE PLAN WORKS

Total Charge	$800.00
Participating Dentist Copay	90%
Non-Participating Dentist	90%

Please note the payments on specific claims will be based on the individual agreement between Oregon Dental Service and the dentist.

EXAMPLE

Participating Dentist	
Participating Dentist total charges	$800.00
Participating Dentist accepted fee; the fee the Participating Dentist has agreed to accept as payment in full	$700.00
Plan pays 90% of Participating Dentist accepted fee (assuming deductible paid)	$630.00
You pay 10% of the Participating Dentist accepted fee (assuming deductible paid)	$70.00
TOTAL AMOUNT YOU WOULD PAY	**$70.00**

Non-Participating Dentist	
Non-Participating Dentist total charge	$800.00
Prevailing Fee as calculated by ODS*	$655.00
Plan pays 90% of Prevailing Fee (assuming deductible paid)	$589.50
You pay 10% of Prevailing Fee (assuming deductible paid)	$65.50
You pay the difference between total charges and Prevailing Fee	$145.00
TOTAL AMOUNT YOU WOULD PAY	**$210.50**

Difference between Participating Dentist and a Non-Participating Dentist	
Your additional responsibility for using a Non-Participating Dentist is	**$140.50**

*Prevailing fee, in Oregon, means the fee for a single procedure which satisfied the majority (equivalent to the fifty-first (51st) percentile) of dentists in Oregon, as determined by Oregon Dental Service based upon a confidential fee listing accepted by Oregon Dental Service from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

Covered Dental Services

Your dental care program covers the following services when performed by a licensed dentist, certified denturist or registered hygienist to the extent that he or she is operating within the scope of his or her license, certificate or registration as required under law in the State of practice; and when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Such standards shall be determined by a panel of dentists and approved by the ODS Health Plans' Board of Directors.

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

Class I Services

A. Diagnostic
Routine examination and x-rays to assist in determining required dental treatment.

B. Preventive
Prophylaxis (cleaning).
Topical application of fluoride.
Space maintainers.
Sealants.

Class II Services

A. Restorative
Provides amalgam fillings on posterior (back) teeth and composite fillings on anterior (front) teeth for the treatment of carious lesions (decay).

Refer to Class II Limitations, Restorative, on page 17.

B. Oral Surgery
Surgical extractions, other minor surgical procedures, general anesthesia or IV sedation when administered by a dentist in connection with a covered oral surgical procedure performed in a dental office.

C. Endodontic
Procedures for pulpal therapy and root canal filling.

Refer to Class II Limitations, Endodontic, on page 17.

D. Periodontic
Surgical and non-surgical procedures for treatment of the tissues supporting the teeth.

E. Miscellaneous
Antibiotic injections.

Class III Services

A. Restorative
Crowns and/or other cast restorations necessary to restore carious lesions (decayed) or broken teeth to a state of functional acceptability. Includes onlays and replacement inlays.

B. Prosthodontic
Bridges, partials, and complete dentures. Includes denture relines and repair of an existing prosthetic device.

C. Non-Surgical Temporomandibular Joint (TMJ) Treatment
Non-surgical treatment for temporomandibular joint (TMJ) and related care procedures for occlusal equilibration and full-mouth reconstruction.

Orthodontic Benefit

Orthodontics is a covered benefit with no waiting period for eligible employees and their covered dependents.

Orthodontics is defined as the procedures of treatment for correcting malpositioned teeth.

Oregon Dental Service will pay **50%** of the participating dentist's charge for orthodontics, up to the maximum benefit. The amount payable to a non-participating dentist will be 50% of the dentist's fees or 50% of the median fee of the participating dentists' filed fee, whichever is less.

The maximum amount payable by ODS for orthodontic benefits to an eligible patient is $1,500.00. The deductible, if any, and the limitations on maximum amounts payable for basic benefits as specified in this Policy shall not apply to orthodontics.

LIMITATIONS

1. The obligation of ODS to make payments for orthodontic treatment will cease upon termination of treatment for any reason prior to completion of the case.

2. ODS will not make payment for repair or replacement of an orthodontic appliance furnished under this program.

3. The obligation of ODS to make payments for orthodontics shall cease on termination of eligibility or of this Policy.

4. If orthodontic treatment has begun before the patient's eligibility date on the Policy, ODS will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

Limitations

GENERAL LIMITATION - OPTIONAL SERVICES

If an eligible person selects a more expensive plan of treatment than is functionally adequate, Oregon Dental Service will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental provider's fee.

Class I Services

A. Diagnostic

1. Examination is covered only once in any six (6) month period. A third examination is allowed within a 12-month period if referred to a specialist. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.

2. Complete mouth x-rays or a panoramic film is covered only once in any three (3) year period, and supplementary bitewing x-rays are covered only once in any six (6) month period.

B. Preventive

1. Prophylaxis (cleaning) or periodontal maintenance is covered only twice in a calendar year. Additional prophylaxis may be covered when medically necessary and additional information is provided from the provider and/or the member to support the need.

2. Topical application of fluoride is covered only once in any six (6) month period for all ages.

3. Sealant benefits are limited to the occlusal surfaces of unrestored primary teeth and unrestored occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

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

Class II Services

A. Restorative

1. Composite, plastic, silicate, or similar restorations in posterior (back) teeth, other than facial Class V restorations on bicuspids, are considered optional services. Coverage shall be made for a corresponding amalgam restoration.

2. Refer to Class III Limitations for further limitation when teeth are restored with crowns or cast restorations.

3. A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered.

B. Oral Surgery

A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.

C. Endodontic

1. A separate charge for cultures is not covered.

2. Pulp capping is covered only when there is exposure of the pulp.

D. Periodontic

1. A separate charge for periodontal charting is not covered.

2. Periodontal scaling and root planing is limited to once per quadrant in any twenty-four (24) month period.

3. Coverage for periodontal maintenance procedure or prophylaxis (cleaning) is limited to twice in a calendar year. Additional prophylaxis may be covered when medically necessary and additional information is provided from the provider and/or the member to support the need.

4. A separate charge for post-operative care done within six (6) months following periodontal surgery is not covered.

A. Restorative

1. Crowns and other cast restorations (including onlays and replacement inlays) are covered once in a five (5) year period on any tooth.

2. Facings are considered cosmetic dentistry if posterior to the maxillary first molar and the mandibular second bicuspid area, and coverage is limited to gold without porcelain.

3. A separate charge for amalgam or composite buildups is not covered.

4. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient and dentist, covered expense will be limited to the cost of amalgam.

B. Prosthodontic

1. Replacement of an existing prosthetic device will be covered only if it is unserviceable and cannot be made serviceable, and a replacement of an existing prosthetic device will be covered once in a five (5) year period.

2. *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 dentures are not covered.

3. *Partial dentures*: If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture.

4. *Denture adjustments and relines:* A separate, additional charge for denture adjustments and relines done within six (6) months after the initial placement is not covered. Subsequent relines will be covered only once in a twelve (12) month period.

5. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to carious lesions (decay).

6. Surgical placement or removal of implants or attachments to implants are not covered. The equivalent amount for the cost of a full or partial denture will be allowed.

7. Fixed bridges or removable cast partials are not covered for patients under age sixteen (16).

8. Facings are considered cosmetic dentistry if posterior to the maxillary first molar and the mandibular second bicuspid area, and coverage is limited to gold without porcelain.

Exclusions

1. The following are not covered:

   - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
   - Services which are provided by any federal, state or provincial government agency, or
   - Services which are provided, without cost to the eligible person, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Policy.

   This exclusion does not apply to medical assistance provided under Medicaid.

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

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

4. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards.

5. Services or supplies for treatment of any disturbance of the temporomandibular joint are excluded, except as covered by the Plan

6. Gnathologic recordings or similar procedures are excluded.

7. Dental services started prior to the date the individual became eligible for such services under the Policy are excluded.

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

9. Hospital charges for services or supplies or additional fees charged by the dental provider for hospital treatment are excluded.

10. Charges for missed or broken appointments are excluded.

11. Experimental procedures or supplies are excluded.

12. This Plan does not cover services rendered or supplies furnished after the date the patient ceases to be eligible hereunder, except for Class III services which were ordered and fitted prior to such date and then only if such items are placed within thirty-one (31) days after such termination of eligibility.

13. This Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.

14. Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, are excluded.

15. Claims submitted more than 15 months after the date of rendition of the service are not covered.

16. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.

Coordination of Benefits

Coordination of Benefits (COB) occurs when you have health care coverage under more than one Plan.

DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following coverages, including Plan coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law;
- Group or individual automobile "no fault" coverage; or
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits that exceeds $100 a day.

Each contract or other arrangement for coverage described above is a separate Plan.

Claimant means the insured person for whom the claim is made.

For definition of **Claim Period** see Definitions Section, paragraph entitled "Claim determination period".

An **Allowable Expense** means any expense which is covered by at least one Plan during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the cash value of the service during a Claim Period will also be considered an Allowable Expense.

If a Plan benefit has a visit, day or dollars paid limitation and the limitation has been met, services in excess of the limitation will not be considered covered expenses for the purpose of this provision.

This Plan is the part of this group contract that provides benefits for health care expenses.

HOW COB WORKS

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

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

The Secondary Plan (the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

WHICH PLAN PAYS FIRST?

When another Plan does not have a COB provision, that Plan is primary, and therefore determines and pays its benefits first. When another Plan does have a COB provision, the first of the following rules that applies will govern:

- **Non-dependent/Dependent.** If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will determine its benefits before a Plan which covers the person as a dependent.

- **Dependent Child/Parents Not Separated or Divorced.** If the claimant is a dependent child whose parents are not divorced or separated and the claimant is eligible for benefits under both parents' plans, then the Plan of the parent whose birthday falls earlier in the calendar year will determine its benefits before the Plan of the parent whose birthday falls later in that year. If both parents' birthdays are on the same day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
- **Dependent Child/Separated or Divorced Parents.** If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:

  - When the parent who has custody of the child has not remarried, that parent's Plan will determine benefits first. When the parent who has custody of the child has remarried then benefits will be determined in this order: first the Plan of the parent with custody of the child, then the Plan of the spouse of the parent with custody of the child, and finally the Plan of the parent without custody.
  - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or non-dependent longer are determined before those of the plan which covered that person for the shorter time.

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

This COB provision will not apply to a claim when the Allowable Expense for a Claim Period is $50 or less. However, if additional expense is incurred during the Claim Period and the total Allowable Expense exceeds $50, then this COB provision will apply to the total amount of the claim.

CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Allowable Expense during the Claim Period.

COB AND PLAN LIMITS

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If this Plan pays more for an Allowable Expense than is required by this provision, the excess payment may be recovered from:

- The claimant;
- Any person to whom the payment was made; or
- Any insurance company, service plan or any other organization which should have made payment.

CORRECTION OF PAYMENTS

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them.

If we make payments that should have been made by another plan, we will have the right to recover them from the person to or for whom they were made, or from insurance companies or other organizations. The person involved must sign any documents that are necessary to enforce our rights under this provision.

Continuation of Coverage

A. Coverage for Spouses Aged 55 Years or Older

The following is applicable to policies issued in Oregon to employers of 20 or more employees. If a spouse is age 55 or older and his or her eligibility for insurance ends due to legal separation, termination of marriage or your death, the spouse will be entitled to continue his or her coverage (including coverage for dependent children) under this Plan. Continuation under this section is not available for any dependent electing coverage under the Continuation of Coverage section beginning on page 28.

In order to be eligible for continued coverage under this section, the spouse must give written notice of the legal separation, termination of marriage or your death to the Plan Administrator within:

- Thirty days of the date of your death;
- Sixty days of the date of legal separation; or
- Sixty days of the date of entry of the divorce decree.

Within 14 days of receipt of the above notice, the Plan Administrator shall notify the spouse that coverage can be continued, and provide an election form to the spouse. The spouse must return the election form within 60 days after the Plan Administrator mails it. Failure of the spouse to exercise the election within 60 days of the notification shall terminate the right to continued benefits under this section.

If the Plan Administrator fails to notify the spouse within the required 14 days, premiums shall be waived until the date notice is received by the spouse.

The monthly premium rate for continued coverage will be the monthly rate that would have been charged if the spouse was an Individual under this Plan plus the premium for coverage of dependent children, if any. Each monthly premium (except the initial premium) must be paid by the spouse to the Plan Administrator within 30 days of the premium due date. The initial premium must be paid by the spouse to the Plan Administrator within 45 days of the date the election to continue coverage is made.

Coverage will be continued until the earliest of:

- The date the spouse becomes covered under any other group health plan;
- The date the spouse becomes entitled to benefits under Medicare;

- The last day of the month for which premiums were paid to us if coverage terminates due to non-payment of premiums; or
- The date the Plan terminates or the date the employer terminates participation under this Plan.

B. Individual Dental Exchange Program

When you lose coverage there is an individual dental plan available to members who have been covered under an employer sponsored ODS dental plan for twelve continuous months prior to their termination date. You must be an Oregon resident to enroll and maintain eligibility for this coverage. The Individual Dental Exchange Program is an individual plan and the benefits are not the same as those you have received under your employer's group dental group. You may enroll in this plan regardless of any other continuation coverage that may be available through your employer. Information regarding this program will be sent to you should you lose coverage under your current employer plan.

CONTINUATION COVERAGE (COBRA)

EXPLANATION OF BENEFIT

IMPORTANT NOTICE

The following section on Continuation Coverage (COBRA) may apply to you. Please check with your employer's Human Resource Department to find out whether you qualify for this coverage. Both you and your spouse should read this notice carefully.

INTRODUCTION

Oregon Dental Service provides benefits to qualified beneficiaries who elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). On behalf of your employer, we have set forth the following summary of your rights and obligations with respect to COBRA coverage. ODS offers no greater COBRA rights than the COBRA statute requires and this notice should be construed accordingly.

COBRA is a federal law requiring most employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event (see below). A qualified beneficiary is someone who is covered under the Plan the day before a qualifying event and is a covered employee or the employee's spouse or dependent child.

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

If you are eligible for continuation coverage, you do not have to show that you are insurable. However, under the law, you may have to pay all of the premium for continuation coverage. You will have a grace period of at least 30 days to pay the premium. The premium rate may include a 2% add-on to cover administrative expenses.

QUALIFYING EVENTS

A. Employee

As an employee covered by the Policyholder's group health plan ("the Plan"), you may elect continuation coverage if you lose coverage for any one of the following three qualifying events:

(1) Termination of employment (other than termination for gross misconduct on your part);
(2) A reduction in hours; or
(3) If you are a retiree, your employer files for reorganization under Chapter 11 of the bankruptcy code.

B. Spouse

If you are the spouse of an employee (or of a retiree for reason 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following five qualifying events:

(1) The death of your spouse;
(2) The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

(3) Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.);
(4) Your spouse becomes entitled (that is, covered) under Medicare; or
(5) Your spouse's employer files for Chapter 11 reorganization.

C. Children

A dependent child of an employee (or of a retiree for reason 6 below) covered by the Plan, has the right to continuation coverage if coverage is lost for **any** of the following six qualifying events:

(1) The death of the employee parent;
(2) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Policyholder;
(3) Parents' divorce or legal separation;
(4) Employee parent becomes entitled (that is, covered) under Medicare;
(5) The dependent ceases to be a "dependent child" under the Plan; or
(6) The employee parent's employer files for Chapter 11 reorganization.

Domestic Partners

A covered employee who, at the time of the qualifying event was covering his or her Domestic Partner under the plan, can elect COBRA continuation coverage that includes continuing coverage for the Domestic Partner. Domestic Partners who are covered under the plan by the covered employee are not “Qualified Beneficiaries” and, therefore, are not independently able to elect COBRA continuation coverage. This also means that the Domestic Partner’s coverage ceases immediately when the employee’s COBRA coverage terminates (for example, due to the employee’s death or because the employee becomes covered by under another plan).

OTHER COVERAGE

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

NOTICE REQUIREMENTS

The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Policyholder if one of these events occurs. Notice must be given no later than 60 days after the loss of coverage under the Plan. When the Policyholder receives timely notice, you, your spouse, and/or dependent child will be notified of your right to continuation coverage. If notice of the event is not timely given, continuation coverage will not be available.

You, your spouse and dependent children will be notified by the Plan Administrator of the right to elect COBRA continuation coverage if any of the following events cause a loss in coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, death of the employee, or the employee's becoming entitled to Medicare.

You or your family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Policyholder sends you or your family member notice of the right to elect continuation coverage. If continuation coverage (discussed below) is not elected, your, your spouse's and your dependent's group health insurance coverage will end.

LENGTH OF CONTINUATION COVERAGE

If you choose continuation coverage, the Policyholder will provide the same coverage as is available to similarly situated employees or dependents under the Plan.

18-Month Continuation Period. When coverage ends due to a termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period will be 18 months from the qualifying event.

29-Month Continuation Period. If a qualified beneficiary is disabled during the first 60 days of continuation coverage following termination of employment or reduction of hours, all qualified beneficiaries under the same qualifying event may continue coverage for up to 29 months from the date the 18-month period began. The 29-month period applies only if the following conditions are satisfied: (1) the Social Security Administration determines the qualified beneficiary is disabled at any time during the first 60 days of continuation coverage; and (2) the qualified beneficiary provides Policyholder a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. The premium for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

36-Month Continuation Period.

- If you (spouse or dependent child) lost coverage because of the employee's death, divorce, legal separation or the employee's becoming entitled to Medicare, or because you (dependent child) lose your status as a dependent under the Plan, the maximum coverage period (for spouse and child) is 36 months from the date of the qualifying event.

- If during an initial 18- or 29-month continuation period, another qualifying event takes place (death of the employee, divorce, or dependent child loses status as a dependent child under the Plan), coverage may be extended to 36 months. In no case will the continuation coverage period exceed 36 months from the date of the qualifying event.

- If you (spouse or dependent child) have continuation coverage due to employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the date the employee became entitled to Medicare.

Note: Longer continuation coverage may be available under Oregon Law for an employee's spouse age 55 and older who loses coverage due to the employee's death, or due to legal separation or divorce. See page 27 for details.

NEWBORN OR ADOPTED CHILD

If, during continuation coverage, a child is born to or placed for adoption with the covered employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The employee or a family member must notify the Policyholder within 30 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Policyholder in a timely fashion, the child will not be eligible for continuation coverage.

SPECIAL ENROLLMENT AND OPEN ENROLLMENT

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

WHEN CONTINUATION COVERAGE ENDS

Continuation coverage will automatically terminate (even before the end of the continuation period) for the employee, spouse and/or dependent child when any one of the following events occurs:

(1) The Policyholder no longer provides health coverage to any of its employees;
(2) The premium for continuation coverage is not paid on time;
(3) You (employee, spouse or dependent child) become covered under another group health plan that has no exclusions or limitations with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies;
(4) You (employee, spouse or dependent child) become entitled (that is, covered) under Medicare;
(5) The Social Security Administration determines that a qualified beneficiary is no longer disabled; or
(6) Coverage is terminated for cause; for example a participant submits a fraudulent claim.

If you have any questions about COBRA, please contact the Policyholder. Notify the Policyholder if you have changed marital status or if you or your spouse have changed addresses.

Claims Administration and Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A. Claim Submission

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than one year from the date submission is otherwise required.

B. Explanation of Benefits (EOB)

Soon after you make a claim, we will report to you on the action we have taken by sending you a document called an Explanation of Benefits. We may pay claims, deny them, or apply the allowable expense toward satisfying the deductible. If we deny all or part of a claim, the reason for our action will be stated in the Explanation of Benefits.

C. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at (503) 948-5560 or toll-free at 1-800-337-3962 or write to our Dental Customer Service Department. We will respond to your inquiry within 30 days of receipt.

APPEALS

A. Definitions

For purposes of this section, the following definitions apply:

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

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

- the specific reason or reasons for the benefit denial,
- reference to the specific Plan provision on which the denial was based,
- a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information.

Post-service claim means any claim for a benefit under a group health plan that is not a pre-service claim.

Pre-service claim means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

A "**claim involving urgent care**" means any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(A) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or,

(B) In the opinion of a dentist with knowledge of the enrollee's dental condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

B. Time Limit for Submitting Appeals

You have **180 days** from the date of an adverse benefit determination to submit a written appeal regarding an adverse determination. If a written appeal is not submitted within the appropriate timeframes as outlined in this section, you will lose your rights to the appeals process. If you do not submit your written appeal on time, you may lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

C. The Review Process

The Plan has a two-level review process. The first level of review is called a First Level Appeal. The second level of review is a Second Level Appeal.

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

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

D. First Level Appeals

You may request that ODS review an adverse benefit determination. Your request, called an appeal, must be in writing. If you need assistance on filing an appeal, contact ODS Dental Customer Service Department at (503) 948-5560 or toll-free at 1-800-337-3962 and ask for assistance. You may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request, and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. ODS's response time to your appeal is based on the nature of the claim. The appeal will receive a full investigation by persons who were not involved in the initial determination.

An appeal related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. An appeal related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the appeal by the plan, unless the enrollee fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, ODS shall notify the enrollee as soon as possible, but no later than 24 hours after receipt of the appeal by the plan, of the specific information necessary to complete the claim. The enrollee shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. ODS shall notify the enrollee of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the plan's receipt of the specified information, or (b) the end of the period afforded the enrollee to provide the specified additional information.

The investigation of an appeal of a **pre-service claim** will be completed within 15 days of receipt of the appeal.

The investigation of an appeal of a **post-service claim** will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, you will receive a written notice of the disposition of your appeal, including the basis for the decision, along with information on your right to a Second Level Appeal.

E. Second Level Appeal

If you disagree with our decision made in response to a First Level Appeal, you may request a review of the decision. Your second appeal must be made within 60 days of the date of our action on your initial appeal. You may also call our Dental Customer Service Department at (503) 948-5560 or toll-free at 1-800-337-3962 to discuss the issue as it may be possible to resolve it without filing a second appeal.

If you request a Second Level Appeal, you should submit your appeal in writing. Your Second Level Appeal will be reviewed by persons who were not previously involved in the review of the First Level Appeal. You have the right to appear before the panel in person or by conference call or other appropriate technology. ODS will allow your representative to act on your behalf in the appeal process if you choose.

A Second Level Appeal of an **urgent care claim** is subject to expedited review and time provisions described above with respect to appeals related to an **urgent care claim**. Investigations and responses to your appeal will follow the same timelines outlined under the First Level Appeal subsection. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. You may expect a written notice of the disposition of your appeal, including the basis for the decision.

BENEFITS AVAILABLE FROM OTHER SOURCES

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

A. Coordination of Benefits (COB)

This provision applies to this Plan when you or your insured dependent have health care coverage under more than one plan. For a complete explanation of COB see the section titled "Coordination of Benefits."

B. Our Right To Be Reimbursed From Third Party Recoveries

An individual covered by us may have a legal right to recover benefits or health care costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or health care costs were paid by us. For example, an individual who is injured may be able to recover the benefits or health care costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for health care expenses connected with the illness or injury. We are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by us through these recoveries help reduce the cost of premiums and providing benefits.

If Benefits have been paid, or payment of Benefits is pending, we are entitled to recover the amount paid or the amount pending payment from the proceeds of any recovery made by a Covered Individual against a Third Party. This right of recovery includes the full amount of the Benefits paid, or pending payment, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or dental/medical expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. Our recovery rights will not be reduced due to the Covered Individual's own negligence.

Definitions:

For purposes of this Section relating to Third Party Recoveries, the following definitions apply:

1. "Covered Individual" means an individual covered by us, including a dependent of a Member/Insured. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or dental/medical expenses of such individual.

2. “Benefits” means any amount paid by us, or submitted to us for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of “Benefits” by the Covered Individual.

3. “Third Party Claim” means any claim, settlement, award, lawsuit, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of dental/medical expenses from us, may file a Third Party claim against the party responsible for the Covered Individual’s injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover Benefits as described herein.)

4. “Third Party” means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. “Third Party” includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage and workers’ compensation insurance.

5. “Recovery Funds” means any amount recovered from a Third Party.

If we have paid any benefits, we will be entitled to recover the amount we have paid from the proceeds of any recovery made by a Covered Individual against a Third Party. Upon claiming benefits, or accepting payment of benefits, or claiming or accepting the provision of benefits from us, the Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. In connection with our rights to obtain reimbursement or exercise our rights as described below, the Covered Individual shall do one or more of the following things and agrees that we may do one or more of the following things, at our discretion:

a. If the Covered Individual seeks payment by us of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a Provider to the Covered Individual.

b. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us.

c. If the Covered Individual makes a demand upon a Third Party, enters into settlement negotiations or commences litigation, the Covered Individual must not prejudice, in any way, our recovery rights under this Section. If a suit is filed by the Covered Individual, the Covered Individual agrees that we may cause to be recorded a notice of payment of Benefits, and such notice will constitute a lien on any judgment or settlement. We may provide notice to the Third Party or its insurer. In the event of settlement, the Covered Individual must obtain our consent prior to releasing any Third Party from liability for payment of any expenses covered, paid or pending for payment by us. The Covered Individual will hold the rights of Recovery Funds in trust for our benefit, up to the amount of Benefits we have paid or which are pending payment at the time of resolution of the Third Party Claim.

d. For any Benefits paid by us or pending payment by us, the Covered Individual shall promptly reimburse us from any Recovery Funds, the full value of any such Benefits paid, provided, or which are pending for payment.

e. To secure our rights to reimbursement for any Benefits paid or provided, the Covered Individual, by claiming or accepting payment or the provision of Benefits by us hereby grants to us a first priority lien against the proceeds of any Third Party Claim and assigns to us any benefits the Covered Individual may have under any insurance coverages, such lien and assignment to apply only to the extent of Benefits paid, provided, or pending for payment.

f. The Covered Individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:

   i. Sign and deliver such documents as we reasonably require to protect our rights;
   ii. Provide any information to us relevant to the application of the provisions of this Section, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and

iii. Take such actions as we may reasonably request to assist us in enforcing our right to be reimbursed from Third Party recoveries.

g. We will pay our proportionate share of the expenses of obtaining Recovery Funds in a Third Party Claim, such as attorney fees and court costs, out of any part of the Recovery Funds which are reimbursed to us by the Covered Individual; otherwise, we have no obligation to pay attorney's fees or costs with respect to litigation to recover Benefits in a Third Party Claim initiated or controlled by the Covered Individual.

h. If the Covered Individual fails to take action to pursue the recovery of damages or benefits from a Third Party, we may assert this recovery right independently from the Covered Individual. This is called a right of subrogation. In such a case, we may initiate the recovery action against the Third Party in our name, or in the name of the Covered Individual, and we shall be entitled to retain from any judgment the full value of the amount of Benefits paid or provided to the Covered Individual and any Benefits which are pending payment, together with all court costs and attorney fees. We shall have no obligation to seek damages or recovery from the Third Party in an amount greater than the Benefits we have paid or may expect to pay in the future, but if a greater amount of damages are demanded and recovered, the remainder of any recovery after we have been fully reimbursed for Benefits paid, court costs and attorney's fees, shall be paid to the Covered Individual or as the court otherwise directs. The Covered Individual agrees to cooperate with us and provide testimony at deposition and at trial or arbitration. If we choose to pursue a subrogation recovery of damages or benefits from a Third Party, we shall not be liable for any attorneys fees or costs incurred by the Covered Individual in connection with the Third Party Claim, and we shall have no obligation to reimburse the Covered Individual for such attorneys fees or costs.

i. We have the right to seek the imposition of a constructive trust on any Recovery Funds or any proceeds received, or to be received, by or on behalf of the Covered Individual arising out of, related to, or in connection with any Third Party Claim.

j. We have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party. If we choose to intervene in the Third Party Claim, we shall not be liable for any attorney fees or costs incurred by the Covered Individual in connection with the Third Party Claim, and we shall have no obligation to reimburse the Covered Individual for such attorneys fees or costs.

k. The Covered Individual agrees that we may seek the imposition of a constructive trust or an equitable lien, or seek restitution, with respect to any Recovery Funds or any proceeds from a Third Party which the Covered Individual has received or may receive.

l. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.

m. The Covered Individual agrees that we may obtain an injunction to prevent the Covered Individual or the Covered Individual's representatives from breaching any provision of this Section or violating any of the Covered Individual's obligations hereunder and/or to require the Covered Individual to comply with the provisions of this Section.

n. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

o. If the Covered Individual continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we will continue to provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing dental/medical treatment have been exhausted for that purpose.

p. Without limiting the Covered Individual's obligations set forth above, we may require the Covered Individual to execute a trust agreement consistent with the provisions of this Section.

q. By accepting Benefits, the Covered Individual instructs his/her legal representatives to comply with the provisions of this Section.

r. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have the right to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or dental/medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify dental/medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.

s. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

t. Coordination of Benefits, where the Covered Individual has health care coverage under more than one Plan or health insurance policy, is not considered a Third Party Claim.

u. If any term, provision, agreement or condition of this Section 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.

C. Motor Vehicle Insurance

We will not pay benefits for health care costs to the extent that a Covered Individual including an insured dependent, is covered by motor vehicle insurance. But we will pay expenses over the amount covered by the motor vehicle insurance, subject to the Third Party Recovery Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the Third Party Recovery Section above.

You must give us information about any dental insurance payments available to the Covered Individual or the Covered Individual's insured dependents.

General Plan Information

The following describes other procedures and policies that we use when processing your claims.

REQUEST FOR INFORMATION

When necessary to process claims, we may require that you submit information concerning benefits to which you or your dependent is entitled. We may also require that you authorize your provider to provide us with information about a condition for which you claim benefits.

DISCLOSURE OF BENEFIT REDUCTION

ODS will provide notification of material reductions in covered services or benefits to the policyholder no later than 60 days after the adoption of the change.

CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of your protected health information is of extreme importance to ODS Health Plans. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. We use your information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For more complete detail about how ODS uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on our website at www.odshealthplans.com or by calling ODS Health Plans at 503-243-4492.

CONSENT TO EXAMINATION OF DENTAL OFFICE RECORDS

By acceptance of the benefits of the Plan, all subscribers or enrollees shall be deemed to have consented to the examination of dental office records for purposes of utilization review, quality assurance, and peer review by the insurer or its designee.

TRANSFER OF BENEFITS

Only you and your insured dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on us.

RECOVERY OF BENEFITS PAID IN ERROR

If we make a payment for you or an insured dependent to which you are not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a physician or provider of services. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for you or any insured dependent even if the payment was not made on that person's behalf.

CONTRACT PROVISIONS

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

WARRANTIES

All statements made by the applicant, policyholder, or an insured person, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting insurance will avoid the insurance or reduce benefits unless contained in a written form and signed by the policyholder or the insured person, a copy of which has been given to the policyholder or to the person or the beneficiary of the person.

RESPONSIBILITY FOR QUALITY OF DENTAL CARE

Oregon Dental Service shall incur no liability whatsoever to any eligible person concerning the selection of dentists to render services hereunder. In performing or contracting to perform dental service, such dentists shall be solely responsible therefore and in no case shall Oregon Dental Service be liable for the negligence of any dentist rendering such services. Nothing contained in this Policy shall be construed as obligating Oregon Dental Service to render dental services.

PROVIDER REIMBURSEMENTS

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

INDEPENDENT CONTRACTOR DISCLAIMER

Oregon Dental Service (ODS) and Participating Dentists are independent contractors. ODS and Participating Dentists do NOT have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of Participating Dentist' provision of dental care to ODS members may be deemed exist or be construed to exist between ODS and Participating Dentists. A Participating Dentist is solely responsible for the dental care provided to any patient, and ODS does not control the detail, manner or methods by which Participating Dentist provides care.

NO WAIVER

Any waiver of any provision of this contract, or any performance under this contract, 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.

GROUP IS THE AGENT

The Group is your and your enrolled dependents' agent for all purposes under this contract. The Group is not the agent of Oregon Dental Service.

GOVERNING LAW

To the extent this contract 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 this contract must be filed in either a state or federal court in the State of Oregon.

TIME LIMITS FOR FILING A LAWSUIT

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

ODS Health Plans Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At ODS Health Plans, we respect the privacy of your protected health information and will maintain its confidentiality in a responsible and professional manner. Protected health information includes any information regarding your health care that can identify you as the recipient of the health care services. We are required by law to provide you with this notice and abide by its terms.

This notice explains how we gather and use information about you and when we can share information with others. It also describes your rights as our valued customer and how you can exercise these rights.

A. How We Collect and Protect Information

We collect information from enrollment or application forms. Examples of information gathered are: Member name, address and Social Security number, general health status information, employment and other information relevant to coverage. We also collect information from insurance transactions with ODS and our affiliates. This includes information such as claims, service authorization requests, deductibles and co-payments. While most information we collect is in writing, we may also gather information in person, by telephone or electronically.

We ensure the security of your information through physical, technical and procedural safeguards. All information collected is treated in a confidential and secure manner whether you are a prospective, current or former customer.

B. How We Use or Share Information

We use protected health information and may share it with others to assist in your treatment, payment for your treatment, and our business operations.

- We will use the information to pay your health care bills that have been submitted to us by dentists, doctors, hospitals and others.
- We may share your information with healthcare professionals to help them provide medical and dental care to you. For example, we may send medical information about you to a specialist as part of a referral.

- We may use or share your information with others to help manage your health care. For example, we may talk to your doctor to suggest a disease management or wellness program that could help improve your health.

In addition, we may use information about you:

- To give you information about alternative medical treatments and programs or about health related products and services you may be interested in. For example, we sometimes send out newsletters to let you know about "healthy living" alternatives such as smoking cessation or weight loss programs.
- For underwriting or other activities relating to the issuance of a contract for health insurance.

We may share your information:

- With a family member or friend to the extent necessary to help with your health care or with payment for your health care when you are unable to provide authorization due to, for example, a medical emergency.
- With authorized private or public entities to assist in disaster relief efforts.
- With other individuals or companies who perform business functions on our behalf, for example, a company that does data entry on our behalf.
- With the plan sponsor, agent or consultant of the employee benefit plan through which you receive health benefits to permit the sponsor to perform plan administration functions.

We will not use or disclose your protected health information unless we are allowed or required by law to do so. The following are additional types of disclosures we may make:

- To state and federal agencies who regulate us. (For example, the US Department of Health and Human Services and the State Insurance Department).
- To authorized public health agencies. For instance, we may report concerns to the Food and Drug Administration regarding prescription drug and medical device problems.
- To appropriate authorities if we believe you are a victim of child abuse or neglect, domestic violence or other crimes.
- To the appropriate agencies if we believe there is a serious health or safety threat to you or others.
- To health oversight agencies for activities authorized by law including audits, criminal investigations, licensure or disciplinary actions.

- To law enforcement agencies for identification and location of a suspect, fugitive, material witness, crime victim or missing person.
- To a court or administrative agency in response to a search warrant, subpoena or other lawful process.
- To coroners, medical examiners and organ procurement entities and for research in limited cases.
- To military authorities and authorized federal officials for intelligence, counterintelligence, and other national security activities.
- To the extent necessary to comply with laws relating to worker's compensation or other similar programs.

Your authorization is required for uses and disclosures other than those allowed or required by law. If you provide authorization for the use and disclosure of your information and later change your mind, you may revoke the authorization.

C. Your Rights

- ***You have the right to request that we not use or disclose your protected health information*** for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. The request must be made in writing. While we will consider your request for restrictions, we are not required to agree to these restrictions.
- ***You have the right to request that your protected health information be communicated to you in a confidential manner*** such as sending mail to an address other than your home. The request must be made in writing. We will accommodate reasonable requests.
- In most cases***, you have the right to inspect and obtain a copy*** of protected health information records that we use to make decisions about your care. Your request must be made in writing. We may charge a reasonable fee for copying and postage.
- If you believe that the protected health information in your record is incorrect or if important information is missing, ***you have the right to request that we amend the records.*** Your request must be in writing and include the basis for your request. We may deny your request if the information was not created by us, if it is not maintained by us, or if we determine that the record is accurate.
- ***You have the right to receive an accounting*** of certain disclosures of your information made by us during the six years prior to your request. The accounting will not include disclosures:

- For treatment, payment, and health care operations purposes;

    - made to you;
    - incident to a use or disclosure otherwise permitted;
    - made pursuant to your authorization;
    - to persons involved in your care
    - for national security or intelligence purposes;
    - to correctional institutions or law enforcement agencies
    - made as part of a limited data set for research, public health, or health care operations purposes; and
    - made prior to April 14, 2003.

We will provide at no charge one accounting upon request every 12 months. We may charge a fee for an additional accounting within 12 months. We will inform you in advance of the fee and allow you to withdraw or modify your request.

D. Exercising Your Rights

- **You have a right to receive a paper copy of this notice upon request at any time**. You can also access this notice on our web site at: www.odshealthplans.com.
- If you have any questions about this notice or about how we use or disclose information, please contact the ODS Privacy Office at 503-243-4492 or 800-852-5195 extension 4492. The office is open Monday through Friday from 8:30 a.m. to 4:30 p.m.
- If you believe your privacy rights have been violated, you may send a complaint to ODS Health Plans, Privacy Office, 601 SW 2nd Avenue, Portland OR 97204.
- You may also file a written complaint with the Department of Health and Human Services (DHHS), Office of Civil Rights. The contact information can be located at www.hhs.gov/ocr You may also contact our office for more specific information.
- We will not take any action against you for filing a complaint.

E. Changes to Our Notice

This notice is effective on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will notify you that a change has been made through your member newsletter and post the notice on our web site at www.odshealthplans.com

601 S.W. Second Avenue
Portland, OR 97204

Telephone Numbers

Member Inquiries		Dental Office Inquiries	
Portland	(503) 948-5560	Portland	(503) 243-4494
Toll Free	1-800-337-3962	Toll Free	1-800-452-1058
TDD/TTY	1-800-433-6313		
(for the hearing and speech impaired)			

www.odshealthplans.com/4j

ODS Health Plans' products provided by Oregon Dental Service.

Form No. 6602-03
Revised 10/2003