Oregon Group Dental Plan

Public Employees Retirement System
Delta Dental PPO Plan

Effective Date: January 1, 2020
Group No. 10004761

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon

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SECTION 1. WELCOME

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

Delta Dental is pleased to have been chosen by the Group as its dental plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Delta Dental's personalized member website, Member Dashboard, at www.modahealth.com/pers. Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

Delta Dental reserves the right to monitor telephone conversations and e-mail communications between its employees and its members for legitimate business purposes as determined by Delta Dental.

This handbook may be changed or replaced at any time, by the Group or Delta Dental, without the consent of any member. The most current handbook is available on Member Dashboard, accessed through the Delta Dental website. All Plan provisions are governed by the Group's policy with Delta Dental. This handbook may not contain every Plan provision.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

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

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that will include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to Member Dashboard or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK

See Network Information (section 3.1) for details about how networks work.

Dental network
Delta Dental Premier Network
Delta Dental PPO Network

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 11 and Section 14.

SECTION 3. USING THE PLAN

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

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

At an initial appointment, members should tell the dentist that they have dental benefits through Delta Dental. Members will need to provide their subscriber identification number and Delta Dental group number to the dentist. These numbers are located on the I.D. card.

3.1 NETWORK INFORMATION

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

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

Members needing dental care may go to any dental office. However, there are differences in reimbursement by Delta Dental for Delta Dental PPO dentists, Delta Dental Premier dentists and out-of-network dentists. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

3.1.1 In-Network Delta Dental Dentists

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

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

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

3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist or dental care provider is paid at the applicable coinsurance and limited to the amount in the PPO Fee Schedule. The member may have to pay the difference between the PPO Fee Schedule amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current contract and returned to the dentist. The member and his or her dentist should review the information before beginning treatment.

SECTION 4. BENEFITS AND LIMITATIONS

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

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

Covered dental services are outlined in 3 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services, and are noted below. See Section 7 for exclusions.

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

Deductible: $25.00
Per member per year, or portion thereof
For in-network benefits, deductible applies to covered Class II and Class III services
For out-of-network benefits, deductible applies to covered Class II and Class III services

Annual maximum plan payment limit: $1,500.00
Per member per calendar year, or portion thereof
Covered Class I services do not apply to the maximum plan payment limit
Members are responsible for expenses that exceed the annual maximum plan payment limit

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

The waiting period will be waived for those members transferring from another group dental plan with 12 months of continuous coverage.

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

4.1 CLASS I: COVERED SERVICES PAID AT 100%.

4.1.1 Diagnostic

a. Diagnostic Services:

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

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive examinations (including problem focused comprehensive examinations) or consultations are covered twice per year.
ii. Limited examinations or re-evaluations are covered twice per year
iii. A separate charge for teledentistry is not covered. Teledentistry is included in the fees for overall patient management.
iv. Complete series x-rays or a panoramic film is covered once in any 5-year period.
v. Supplementary bitewing x-rays are covered once per year.
vi. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
vii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.

4.1.2 Preventive

a. Preventive Services:

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

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year.
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and over, topical application of fluoride is covered twice per year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
iv. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.

v. Space maintainers are a benefit once per space for members under age 14. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

4.2 CLASS II: COVERED SERVICES PAID AT 80%.

4.2.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.3.1.
iv. Replacement of a stainless steel crown by the same dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.

4.2.2 Oral Surgery

a. Oral Surgery Services:

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

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.
ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.

4.2.3 Endodontic

a. Endodontic Services:

i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling)

b. Endodontic Limitations:

i. A separate charge for cultures is not covered.
ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. Pulp capping is covered only when there is exposure of the pulp.

iv. Cost of retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

4.2.4 Periodontic

a. Periodontic Services:

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

b. Periodontic Limitations:

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

4.2.5 Anesthesia

a. General anesthesia or IV sedation

Covered only:

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

4.3 CLASS III: COVERED SERVICES PAID AT 50%.

4.3.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 4.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iii. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be

limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

4.3.2 Prosthodontic

a. Prosthodontic Services:

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

b. Prosthodontic Limitations:

i. A bridge or a full or partial denture will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
iv. Denture adjustments, repairs, and relines*:* A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
v. Tissue conditioning is covered no more than twice per denture in a 3-year period.
vi. Surgical placement and removal of implants is covered. Implant placement and removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years. The Plan will also cover:
    A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
    B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device; or
    C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.
    D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth.

E. These benefits or alternate benefits are not provided if the tooth, implant or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

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

viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

4.3.3 Other

a. Other Services:

i. Athletic mouthguard

b. Other Limitations:

i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.

ii. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

4.4 General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, Delta Dental will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the dentist's fee.

SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

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

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

Delta Dental has developed a program that provides additional cleanings (prophylaxis or periodontal maintenance) for Delta Dental members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in Section 4.

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

Keeping the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

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

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

5.1.3 How to Enroll

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

SECTION 6. HEALTH THROUGH ORAL WELLNESS PROGRAM

Delta Dental's Health through Oral Wellness program offers enhanced benefits, see section 6.3, to members at high risk of tooth decay, gum disease and oral cancer as determined by a clinical risk assessment administered by a dentist registered with the program.

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

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

To find a dentist registered with the Health through Oral Wellness program in Oregon, members can log in to their Member Dashboard account at www.modahealth.com/pers and select Find Care.

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

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

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

6.2 Clinical Risk Assessment

Clinical risk assessments objectively determine a member's risk of tooth decay, gum disease or oral cancer. A member who is determined high risk in one of these three categories is informed of his or her enhanced benefits by the registered dentist. Members may be eligible for enhanced benefits based on more than one risk category. A clinical risk assessment that covers all three risk categories is called a comprehensive risk assessment.

6.2.1 Tooth Decay Risk Assessment

A member who is eligible for enhanced benefits based on his or her risk of tooth decay must take a tooth decay risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain his or her eligibility. Eligibility for enhanced benefits will continue regardless of the member's risk score for tooth decay at a subsequent risk assessment provided there is no lapse in eligibility.

6.2.2 Gum Disease Risk Assessment

A member who is eligible for enhanced benefits based on his or her risk of gum disease must take a gum disease risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain his or her eligibility. Eligibility for enhanced benefits will continue regardless of the member's risk score for gum disease at a subsequent risk assessment provided there is no lapse in eligibility.

6.2.3 Oral Cancer Risk Assessment

A member who is eligible for enhanced benefits based on his or her risk of oral cancer must take an oral cancer risk assessment or comprehensive risk assessment every 6 to 14 months in order to maintain his or her eligibility. A member's oral cancer risk score may affect his or her eligibility for enhanced benefits, see section 6.4 for more information.

6.3 ENHANCED BENEFITS

6.3.1 Tooth Decay and Gum Disease Enhanced Benefits

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

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

6.3.2 Oral Cancer Enhanced Benefits

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

6.3.3 Limitations

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

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

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

With the exception of tobacco cessation counseling, enhanced benefits may not be combined with the additional benefits available through the Oral Health Total Health program described in Section 5.

6.4 WHEN ENHANCED BENEFITS END

If a member does not receive continued clinical risk assessments as required in section 6.2, eligibility for enhanced benefits will end. Standard plan benefits, see Section 4, will resume 14 months from the last clinical risk assessment.

A member's tobacco cessation counseling enhanced benefit will end if a subsequent clinical risk assessment determines that the member is no longer at high risk for oral cancer.

SECTION 7. EXCLUSIONS

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

Analgesics
Substances used for the purpose of pain relief

Anesthesia or Sedation
Local anesthetics, nitrous oxide, general anesthesia and/or IV sedation except as stated in section 4.2.5

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

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

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service, except as stated in section 10.1

Congenital or Developmental Malformations
Including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth)

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

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

Duplication and Interpretation of X-rays or Records

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

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

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

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

Hypnosis

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

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

Instructions or Training
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction except as allowed under Health Through Oral Wellness as seen in Section 6

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

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

Maxillofacial Prosthetics
Except for surgical stents as stated in section 4.3.2

Missed Appointment Charge

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

Orthodontia

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

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

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

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except athletic mouthguards as provided in section 4.3.3. Excluded services include increasing vertical dimension, equilibration, occlusal guards and periodontal splinting

Self Treatment
Services provided by a member to himself or herself

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

Services on Tongue, Lip, or Cheek

Services Otherwise Available
Including those services or supplies:

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

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. (see section 10.3).

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ).

Treatment After Coverage Terminates
Except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends. This provision is not applicable if the Group transfers its plan to another carrier.

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

Treatment of Closed Fractures

SECTION 8. ELIGIBILITY

All present and future PERS retirees who are receiving a retirement or disability allowance under one of the systems are eligible for this dental care program in accordance with the requirements set forth in the Plan. The subscriber must reside in the United States and be enrolled in one of the PERS sponsored medical plans currently available.

8.1 ELIGIBLE PERSONS

A person is eligible to enroll in the Plan if he or she:

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

8.2 DEPENDENT CHILDREN

A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are also subject to the Plan's child age limit. Legal custody or guardianship does not apply.

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

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

A subscriber's child who has sustained a disability making him or her physically or mentally incapable of self-support at even a sedentary level, that child may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have arisen, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Delta Dental will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

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

Delta Dental will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Delta Dental will be required on an ongoing basis except in cases where the disability is certified to be permanent.

8.3 DEPENDENT DOMESTIC PARTNERS

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

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

8.4 NEW DEPENDENTS

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

8.5 ELIGIBILITY AUDIT

Delta Dental reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee retirement applications, member birth certificates, adoption paperwork, marriage certificates, domestic partnership documents and any other evidence necessary to document eligibility on the Plan.

SECTION 9. ENROLLMENT

9.1 ENROLLING ELIGIBLE PERSONS

9.1.1 New Retiree

New retirees and their eligible spouses, dependent domestic partners or dependent children may enroll by completing an enrollment request form and submitting it to the Group within 90 days of the effective date of their PERS retirement, within 90 days of the date of the Notice of Award letter issued by the Social Security Administration or within 90 days of the date of the Disability Approval Letter for a person who receives retroactive eligibility for disability retirement. Coverage will begin on the PERS retirement effective date if applying before the retirement date or on the first day of the month following receipt of the completed enrollment request form if applying after the retirement date.

9.1.2 Medicare Eligibility

Retirees or their eligible spouses, dependent domestic partners or dependent children may enroll by filling out an enrollment request form and submitting it to the Group within 90 days of the date of initial Medicare eligibility if enrolled in both Part A and Part B. For a person who receives retroactive eligibility for Medicare as a result of an appeal to an initial denial for eligibility, the enrollment form must be submitted within 90 days from the date the person is notified of his or her enrollment in Medicare. Coverage will begin on the date Medicare coverage becomes effective if applying before the date of Medicare eligibility and on the first day of the month following receipt of the enrollment form if applying after the date of Medicare eligibility.

9.2 WHEN COVERAGE BEGINS

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

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

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

When a new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the PERS Office determines that an applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

The necessary premiums must also be paid for coverage to become effective.

9.3 WHEN COVERAGE ENDS

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

9.3.1 Termination of the Group Plan

If the Plan is terminated for any reason, coverage ends for the Group and members on the date the Plan ends.

9.3.2 Termination by a Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving Delta Dental written notice through the Group. Coverage ends on the last day of the month through which premiums are paid.

9.3.3 Subscriber's Death

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

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

9.3.4 Loss of Eligibility by Dependent

Coverage ends

a. for an enrolled spouse on the date he or she becomes eligible as a retiree or surviving dependent under the Plan or on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal).
b. for an enrolled dependent domestic partner on the date he or she becomes eligible as a retiree or surviving dependent under the Plan or on the last day of the month in which the domestic partnership no longer meets the requirements of the Affidavit of Domestic Partnership filed with the Group.
c. for an enrolled child on the last day of the month in which he or she turns age 26 or that a legal guardianship ends.

The subscriber must notify Delta Dental when a marriage, domestic partnership or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends. See Section 12 for details.

9.3.5 Medicare Eligibility

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

9.3.6 Rescission

Delta Dental may rescind a member's coverage back to the effective date, or deny claims at any time for fraud, or intentional material misrepresentation by the member or the Group. This may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility, and falsification or alteration of claims. Delta Dental reserves the right to retain premiums paid as liquidated damages, and the Group and/or member shall be responsible for the full balance of any benefits paid. Delta Dental will notify a member of a rescission 30 days before cancellation of coverage. Should Delta Dental terminate coverage under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of any affiliates.

9.3.7 Continuing Coverage

Information is in Continuation of Dental Coverage (Section 12).

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION AND PAYMENT OF CLAIMS

10.1.1 Claim Submission

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

10.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through Member Dashboard. Delta Dental may pay claims, deny them, or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.1.

10.1.3 Claim Inquiries

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

10.2 APPEALS

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

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

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

Appeal is a written request by a member or his or her representative for Delta Dental to review an adverse benefit determination.

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

10.2.2 Time Limit for Submitting Appeals

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

10.2.3 The Review Process

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

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

Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

10.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. The member may review the claim file and submit evidence as part of the appeal process, and may appoint a representative to act on his or her behalf. Delta Dental will send a letter no more than 7 days after receiving an appeal to tell the member that the appeal is received. Appeals are investigated by persons who were not involved in the original decision.

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

10.2.5 Second Level Appeal

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. A second level appeal must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions, and will follow the same timelines as those for a first level appeal. The member may review the claim file and submit evidence as part of the appeal process, and may appoint a representative to act on his or her behalf. Delta Dental will notify the member in writing of the decision, including the basis for the decision.

10.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has healthcare coverage under more than one plan.

If the member 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 any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

10.3.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, (e.g., an employee, member of an organization, primary insured or retiree) then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.

b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)

c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.

e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

10.3.1.2 How COB Works

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

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

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that Delta Dental will not pay any more than it would have paid if it had been the primary plan. In

consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

10.3.1.3 Effect on the Benefits of This Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

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

10.3.1.4 Definitions

For purposes of this section, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

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

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

Complying plan is a plan that follows these COB rules.

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

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

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

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

This Plan is the part of this group policy that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing dental benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

10.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by Delta Dental.

The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member Delta Dental will pay a member's expenses based on the understanding and agreement that Delta Dental is entitled to be reimbursed to the extent allowed under Oregon law from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that Delta Dental has the rights described in section 10.3.2. Delta Dental may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Delta Dental's right of recovery or subrogation as discussed in this section. Delta Dental has discretion to interpret and construe these recovery and subrogation provisions.

10.3.2.1 Definitions:

For purposes of section 10.3.2, the following definitions apply:

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

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

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

10.3.2.2 Subrogation

Upon payment by the Plan, Delta Dental has, to the extent consistent with Oregon law the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. Delta Dental is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

10.3.2.3 Right of Recovery

In addition to its subrogation rights, Delta Dental may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply:

a. The member holds any rights of recovery against the third party in trust for Delta Dental, but only for the amount of benefits Delta Dental paid for that illness or injury to the extent the amount is consistent with Oregon law.

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

c. If Delta Dental requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to Delta Dental a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. This right of recovery includes the full amount of the benefits paid or pending payment by Delta Dental, out of any recovery made by the member from the third party that Delta Dental is allowed to recover consistent with Oregon law, including without limitation any and all amounts (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. Delta Dental's recovery rights will not be reduced due to the member's own negligence.

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

f. In third party claims involving the use or operation of a motor vehicle, Delta Dental, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon or under other applicable state law.

10.3.2.4 Additional Provisions

Members shall comply with the following and agree that Delta Dental may do one or more of the following, at its discretion:

a. The member shall cooperate with Delta Dental to protect its recovery rights, including by:

    i. Signing and delivering any documents Delta Dental reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
    ii. Providing any information to Delta Dental relevant to the application of the provisions of section 10.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments

iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.
iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing its third party recovery rights

b. The member and his or her representatives are obligated to notify Delta Dental 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 member is seeking recovery of benefits paid by Delta Dental from the third party

c. By accepting payment of benefits by the Plan, the member agrees that Delta Dental has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 10.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.3.2.

f. Section 10.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Delta Dental.

g. Coordination of benefits (where the member has dental/medical coverage under more than one plan or health insurance policy) is not considered a third party claim.

SECTION 11. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give or authorize a provider to give Delta Dental any information needed to pay benefits. Delta Dental may release to or collect from any person or organization any needed information about the member.

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Delta Dental. Protected health information includes enrollment, claims, and medical and dental information. Delta Dental uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how Delta Dental uses members' information. A copy of the notice is available on the Delta Dental website by following the HIPAA link or by calling 503-243-4492.

11.3 TRANSFER OF BENEFITS

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

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

11.5 CORRECTION OF PAYMENTS

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

11.6 CONTRACT PROVISIONS

The policy between Delta Dental and the Group and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or

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

11.7 WARRANTIES

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

11.8 LIMITATION OF LIABILITY

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

11.9 PROVIDER REIMBURSEMENTS

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

11.10 INDEPENDENT CONTRACTOR DISCLAIMER

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

11.11 No Waiver

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

11.12 Group is the Agent

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

11.13 Governing Law

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

11.14 Where any Legal Action Must be Filed

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

11.15 Time Limits for Filing a Lawsuit

Any legal action arising out of, or related to, the Plan and filed against Delta Dental by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

SECTION 12. CONTINUATION OF DENTAL COVERAGE

The following sections on continuation of coverage may apply. Members should check with the PERS Health Insurance Program to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

12.1 OREGON CONTINUATION COVERAGE FOR SPOUSES & DEPENDENT DOMESTIC PARTNERS* AGE 55 AND OVER

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

12.1.1 Introduction

55+ Oregon Continuation only applies to employers with 20 or more employees. Delta Dental will provide 55+ Oregon Continuation coverage to those members who elect coverage under ORS 743B.343 to 743B.345, subject to the following conditions:

a. Delta Dental will offer no greater rights than ORS 743B.343 to 743B.345 requires
b. Delta Dental will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. If the Group or its designated third party administrator fails to notify the eligible spouse or dependent registered domestic partner of their continuation rights, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or dependent registered domestic partner. The Group shall be responsible for such premiums.

12.1.2 Eligibility

The spouse or dependent registered domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or dependent registered domestic partner is 55 years of age or older at the time of such event
c. The spouse or dependent registered domestic partner is not eligible for Medicare

12.1.3 Notice and Election Requirements

Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

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

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

Election. The surviving, legally separated or divorced spouse or dependent registered domestic partner, must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

12.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse or dependent registered domestic partner, to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

12.1.5 When Coverage Ends

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

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan ends, unless a different group policy is made available to Group members
c. The date the member becomes insured under any other group dental plan
d. The date the member remarries or registers another domestic partnership
e. The date on which the member becomes eligible for Medicare.

12.2 COBRA CONTINUATION COVERAGE

12.2.1 Introduction

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

a. Delta Dental will offer no greater COBRA rights than the COBRA statute requires
b. Delta Dental will not provide COBRA coverage for members who do not comply with the requirements outlined below
c. Delta Dental will not provide COBRA coverage if the COBRA Administrator does not provide the required COBRA notices within the statutory time periods or if the COBRA Administrator otherwise does not comply with any of the requirements outlined below

d. Delta Dental will not provide a disability extension if the COBRA Administrator does not notify Delta Dental within 60 days of its receipt of a disability extension notice from a member

For purposes of section 12.2, Plan Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration. Specific qualifying events are listed below.

12.2.2 Qualifying Events

a. **Subscriber.** A subscriber may elect continuation coverage if coverage is lost because of termination of PERS retirement status.

b. **Spouse.** The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

   i. Death of the subscriber
   ii. Termination of the subscriber's PERS retirement status
   iii. Divorce or legal separation from the subscriber
   iv. Subscriber becomes entitled to Medicare

   (If it can be established that a subscriber has eliminated 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 COBRA Administrator within 60 days of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.)

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

   i. Death of the subscriber
   ii. Termination of the subscriber's PERS retirement status
   iii. Parents' divorce or legal separation
   iv. Subscriber becomes entitled to Medicare
   v. Child ceases to be a "child" under the Plan

d. **Dependent Domestic Partners.** A subscriber, who at the time of the qualifying event was covering his or her dependent domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the dependent domestic partner. A dependent domestic partner who is covered under the Plan by the subscriber is not an eligible member under COBRA and, therefore, does not have an independent election right under COBRA. This also means that the dependent domestic partner's coverage ends immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

12.2.3 Other Coverage

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

12.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage ends 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 subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce): and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of PERS retiree status, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage will end.

A subscriber 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 subscriber does not.

12.2.5 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. Delta Dental will not send a bill for any payments due. The member is responsible for paying the applicable premiums when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

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

12.2.6 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost due to a termination of PERS retirement status, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. When coverage is lost due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members other than the subscriber who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months ***before*** the termination or reduction of hours.

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death. Coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

12.2.7 Extending the Length of COBRA Coverage

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

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of PERS retirement status may be extended to a total of up to 29 months. The disability must have started before the 61st day after the subscriber's termination of PERS retirement status and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of PERS retirement status. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination
b. the date of the termination of PERS retirement status
c. the date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination of PERS retiree status

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of PERS retirement status. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of PERS retirement status.)

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or dependent registered domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 12.1).

12.2.8 Newborn or Adopted Child

If a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements e.g., age). The subscriber or a family member must notify the COBRA Administrator within 30 days of the birth or placement to obtain continuation coverage. If COBRA Administrator is not notified in the required timeframe, the child will not be eligible for coverage.

12.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or dependent domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 8.4 and 9.1), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. any required premiums are not paid in full on time

b. a member becomes covered under another group dental plan
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. the Group ceases to provide any group dental plan for its members
e. during a disability extension period (see section 12.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will terminate)

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

Questions about COBRA should be directed to the Plan Administrator. The Plan Administrator should be informed of any address changes.

SECTION 13. DEFINITIONS

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

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

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

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

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

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

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

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

Coinsurance means the percentages of covered expenses to be paid by a member.

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

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

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

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

Deductible is the amount of covered expenses that are paid by a member before benefits are payable by the Plan.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor.

Dentally Necessary means services that:

a. are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan;

b. are appropriate with regard to standards of good dental practice in the service area;
c. have a good prognosis;
d. are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

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

Dentist means a licensed dentist, to the extent that he or she is operating within the scope of his or her license as required under law within the state of practice.

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

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

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

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

Eligible Person means any person who has met the eligibility requirements to be enrolled on the Plan (see section **Error! Reference source not found.**).

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

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

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

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

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

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

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

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

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

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

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

Member means a subscriber, dependent of a subscriber or a person otherwise eligible for the Plan who has enrolled for coverage under the terms of the Plan.

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

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

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

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

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

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

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

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

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

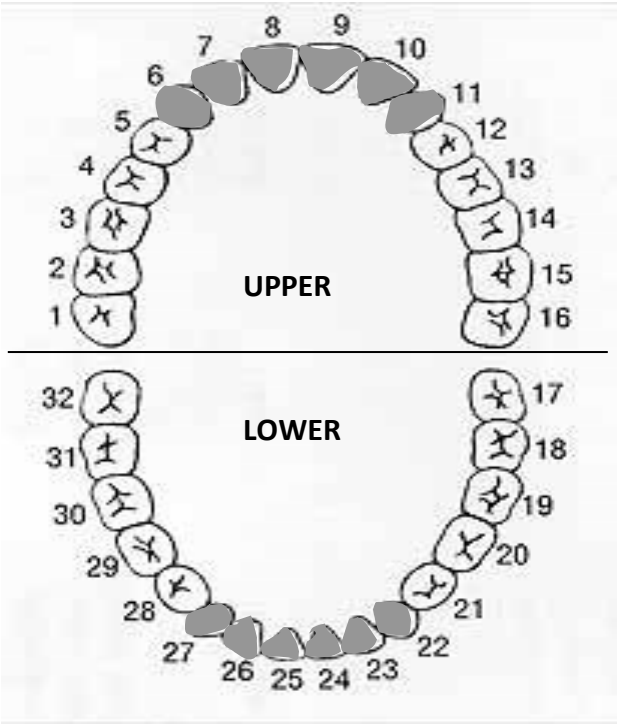
Veneer is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast)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

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

SECTION 14. TOOTH CHART

The Permanent Arch

R I G H T



L E F T

Anterior teeth are shaded gray.

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

Nondiscrimination notice

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

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

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

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

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

modahealth.com

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

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

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

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

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

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

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

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

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

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

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

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