OEBB

Dental Plan 4 with Orthodontia

Effective Date October 1, 2008

Member handbooks and other services are available at **www.odscompanies.com.**

Administered by Oregon Dental Service.

Welcome Using Your Program

Welcome to Oregon Dental Service (ODS). Created in 1955, ODS was the first company in America to provide prepaid dental coverage.

Our dental plans are easy to use and cost effective. If you choose a Participating Dentist from the ODS Premier Dental Directory (which is available on the ODS website at www.odscompanies.com under "Provider Search"), all of the paperwork takes place between our office and your dentist's office. More than 90% of all licensed dentists in Oregon are ODS Participating Dentists. For travelers and employees outside Oregon, our national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

When you need dental care you may use any dental provider. However, **there are differences in reimbursement by ODS for Participating Dentists and Non-participating Dental Providers.** An example is provided on page 26. While an enrollee may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

During your first appointment, tell your dental provider that you have dental benefits through ODS. You will need to provide your subscriber identification number and ODS Group number. These numbers are located on your I.D. card.

For expensive treatment plans, ODS provides a predetermination service. Your dentist may submit a predetermination request to get an estimate of what your insurance would pay. The predetermination will be processed according to your plan's current contract and returned to your dental provider. You and your dental provider should review the information before beginning treatment.

If you have questions about your plan, contact ODS' Customer Service Department you may also visit our website at **www.odscompanies.com** to access your myODS account.

ODS Customer Service Department

Portland	503-265-2910
Toll Free	1-866-923-0410
TDD/TTY	1-800-433-6313
	(for the hearing and speech impaired)
En Español	503-265-2963
Llamado Gratis	1-877-299-9063

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

Please note: This handbook is a description of your dental care program. All Plan provisions are governed by OEBB's Policy with ODS. This handbook may not contain every Plan provision. All provisions or terms of the Policy not described in this handbook still apply.

Table of Contents

General Plan Information

1. **Plan Name:**
   OEBB

2. **Plan Sponsor:**
   Oregon Educators Benefit Board
   1225 Ferry Street SE
   Salem, Oregon 97301
   503-378-3329

3. **Employer Identification Number:** 41-2246536

4. **Agent for Legal Process:** The Plan Sponsor named above.

5. **Type of Plan:** Employee Dental Benefit Plan**.**

6. **Plan Year:** October 1st through September 30th**.**

7. **Plan Administrator**: The Plan Sponsor is the administrator of the Plan.

8. **Funding Medium and Type of Plan Administration**: Benefits are provided under a group insurance policy entered into between OEBB and Oregon Dental Service. Claims for benefits are sent to ODS. ODS, not OEBB, is responsible for paying claims.

   The Plan is funded by employer and/or employee contributions. The amount of total contributions is determined by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is determined by OEBB and the Participating District.

9. **Provider of Benefits**: Benefits are provided in accordance with a Policy of Insurance between Oregon Dental Service and Oregon Educators Benefit Board.

Definitions

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

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

Accepted Fee means the filed fee approved by ODS for a specific dental procedure performed by a Participating Dentist submitting that fee and performing that dental service. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to our Dental Consultant who determines a comparable code to the one billed. ODS will use the Maximum Plan Allowance for the comparable code to price the claim.

Affidavit of Dependency means a notarized document that attests that a child meets the criteria in the definition of Dependent Child.

Affidavit of Domestic Partnership means a notarized document that attests the Eligible Employee and one other eligible individual meet the criteria definition of Unregistered Domestic Partner.

Alveolar Structures are the upper and lower jaw bones.

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. (see tooth chart)

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

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

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

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. Abutment 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 patient's tooth that is made at a laboratory and cemented into the tooth.

Claim Determination Period means the plan year or portion thereof commencing October 1st of any calendar year and ending September 30th of the subsequent calendar year.

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

Co-pay or Co-payment means the relative percentages to be paid by the enrollee.

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 the Enrollee before benefits are payable by the Plan.

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

Dentally Necessary means:

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

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

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 individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant. For more information, see Eligibility.

Domestic Partners see Registered Domestic Partner and Unregistered Domestic Partner.

Eligible Employee means an:

- **Active Employee** of a Participating District who is employed on a half-time or greater basis or is in a job-sharing position or meets the definition of an Eligible employee under an OEBB rule or under a collective bargaining agreement; or a
- **Retired Employee** who was a previously active Eligible Employee. For complete information, see page 8.

Eligibility Waiting Period means the period of employment or membership with the Participating District that a prospective enrollee must complete before coverage begins.

Enrolled Dependent means an eligible dependent of an enrolled employee of the Participating District, whose application has been accepted by OEBB and who is enrolled in this Plan.

Enrolled Employee means an employee of the Participating District, who is enrolled in this Plan following acceptance by OEBB of that person's application.

Enrollee means an employee, dependent of the employee or an individual otherwise eligible for this Policy who has enrolled for coverage under the terms of this Policy.

Enrollment date means, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the eligibility waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

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

Late Enrollee means an individual who enrolls subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. If you decline coverage for yourself and/or your dependents when initially eligible, you will not be allowed to enroll yourself and or your dependents until the next open enrollment period. (See page 13 for complete details.)

An individual is not a late enrollee if:

- The individual qualifies for special enrollment as described on page 12 The individual applies for coverage during an open enrollment period;
- A court has ordered that coverage be provided for a Spouse or minor child under a covered employee's dental benefit plan and request for enrollment is made within 30 days after issuance of the court order;
- The individual is employed by an employer who offers multiple dental benefit plans and the individual elects a different dental benefit plan during an open enrollment period; or
- The individual's coverage under a publicly sponsored or subsidized health plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group dental benefit plan.

Maximum Payment Limit means the amount payable by the program for covered services received each plan year, or portion thereof, for each enrollee.

Maximum Plan Allowance
For a Participating Dental Provider, the maximum amount is based on a fee filed with ODS. For Non-participating Dental Providers, the maximum amount is based on a per service average allowance of the Participating Dentists' filed fees. *The Non-participating Dentist has the right to bill the difference between the ODS Maximum Plan Allowance and the actual charge. This difference will be a patient responsibility.*

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

Non-participating Dental Providers means those dental providers who are not participating.

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

ODS means Oregon Dental Service, a not-for-profit dental healthcare service contractor.

Oregon Educators Benefit Board (OEBB) means the state agency and program established in the State of Oregon, Department of Administrative Services by Senate Bill 426 and that is overseen by the OEBB Board.

Palliative Treatment is treatment performed only to control pain, swelling, or bleeding in or around the teeth and gums. Palliative treatment does not include follow-up care or definitive restorations such as, but not limited to, crowns, extractions, or root canal treatment.

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

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

Participating District means a common school district, a union high school district, an education service district, or a community college district that participates in Benefit Plans provided by OEBB.

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

Periodontal Maintenance is a periodontal procedure for enrollees 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).

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

The **Plan** is the agreement between OEBB and Oregon Dental Service. which contains all the conditions of the Plan. This Member Handbook is a part of the Plan.

The **Policyholder** is the OEBB, for whose members or employees of Participating Districts these medical benefits are being provided.

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. (see tooth chart)

Prophylaxis is cleaning and polishing of all teeth.

Registered Domestic Partner means an individual of the same sex joined with the employee in a partnership that has been registered in Oregon according to the Oregon Family Fairness Act.

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.

Spouse means a person of the opposite sex who is a husband or wife. The definition of Spouse does not include a former Spouse and a former Spouse does not qualify as a dependent.

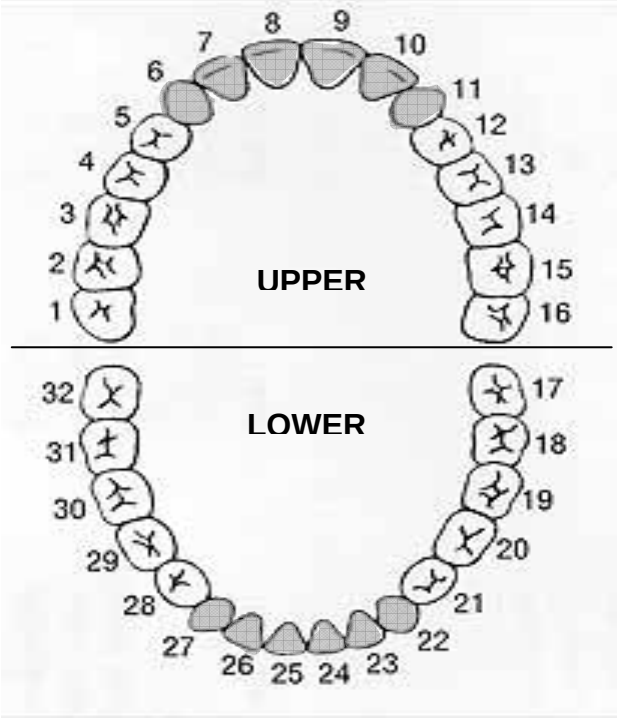
Unregistered Domestic Partner means an individual of the same or opposite sex who is not married or registered in Oregon under the Oregon Family Fairness Act, and has entered into a partnership that meets the following criteria:

- Both are at least 18 years of age;
- Are responsible for each other's welfare and are each other's sole Domestic Partners;
- Are not married to anyone and either has not had a Spouse, a Registered Domestic Partner or another Unregistered Domestic Partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;
- Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
- Have jointly shared the same regular and permanent residence for at least six months; and
- Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

Veneer (chairside and laboratory) 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.

Tooth Chart – The Permanent Arch

RIGHT



LEFT

Note: 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)

Eligibility

This section describes who is eligible to enroll in the Plan. Please be aware that the date you become eligible may be different than the date coverage begins. See "When Coverage Begins" for more specific information. This is located in the "Enrollment" section beginning on page 13.

ACTIVE EMPLOYEES

Employee Eligibility
You are eligible to enroll in the Plan if you:

- Are paid on a regular basis through the payroll system, have federal taxes deducted from such pay, and are reported to Social Security;
- Work for the Participating District on a regularly basis at least:
  - 17.5 hours per week;
  - such number mutually agreed upon by the school district and OEBB; or
  - you are untitled to coverage under an employment contract.
- Satisfy any eligibility waiting period; and
- Apply to and are accepted by OEBB to be included in this Policy.

You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993, as amended.

Dependents
Your legal Spouse or Registered Domestic Partner is eligible for coverage. Your Unregistered Domestic Partner is eligible for coverage if he or she complies with the Domestic Partner Affidavit provided by the Participating District. Your dependent children are eligible until their 19th birthday. Your dependent children may be eligible until their 26th birthday if they are not married, are not in a Registered Domestic Partnership, are not in an Unregistered Domestic Partnership and:

- Are a full-time student at an accredited college, university, or vocational school;
- Are living in the home of the Eligible Employee over six months of the calendar year and the Eligible Employee provides over half of the yearly support; or
- Are incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

Children eligible due to a court or administrative order are also subject to the Plan's child age limits.

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

- A biological child of, an adopted child of, or a child placed for adoption with the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner;
- A legal ward by court decree, a dependent by Affidavit of Dependency, or is under legal guardianship of the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner, and is living in the home of the Eligible Employee;
- The child must not qualify as any other person's Dependent Child, except that a child of divorced or separated parents meeting conditions under IRC 152(e) can be treated as a dependent of both parents; or
- A newborn child of a covered dependent for the first 31 days of the newborn's life.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 19 years old. To be eligible, the child must be unmarried, not in a Registered or Unregistered Domestic Partnership, principally dependent on you for support, and must have had continuous medical insurance coverage (group or individual) prior to attaining age 26 and until the time of the OEBB insurance effective date. The incapacity must have arisen before the child's 19th birthday. You must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 19th birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

Dependents on full time duty in the active military service of the United States are *not* eligible. This includes members of the Reserve Components serving on active duty or full-time training duty.

Note:

- **Some Participating Districts may not offer opposite sex domestic partner coverage. Check with your Participating District to determine what domestic partner coverage is available.**
- **Your Participating District may offer other dependent coverage limitations due to a collective bargaining or district policy. Check with your Participating District for dependent coverage limitations.**

Qualified Medical Child Support Order (QMCSO)

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

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Plan Administrator determines that the applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

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

RETIREES

Employee Eligibility

You are eligible to enroll in the Plan if you:

- Were a previously active employee;
- Are receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability Benefit Plan or system offered by an OEBB participating organization for its Employees;
- Are eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;

- Are eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or
- Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEBB participating organization and has reached earliest retirement age under the plan or system.

Dependent Eligibility
If a retiree becomes eligible for Medicare coverage, but his or her currently-enrolled eligible dependents are not, these eligible individuals may continue OEBB medical and dental insurance coverage until such time as they no longer meet OEBB eligibility requirements or become eligible for Medicare coverage, whichever occurs first. The eligible individuals must submit the application for enrollment to the retiree plan administrator within 60 days of the retiree's eligibility for Medicare.

When Retiree Eligibility Ends
A retiree and eligible dependents enrolled in OEBB retiree insurance plans who become eligible for Medicare coverage may not continue an OEBB retiree medical insurance plan. The exception is for Medicare eligibility as a result of end-state renal disease. Insurance coverage ends the last day of the month that eligibility is lost.

NEW DEPENDENTS

If you marry while you are enrolled in this Plan, your Spouse and his or her children are eligible for coverage. A complete and signed application along with a valid marriage certificate must be submitted within 31 days of the date of the marriage. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you register a Declaration of Domestic Partnership under the Oregon Family Fairness Act while you are enrolled in this Plan, your Registered Domestic Partner and his or her children are eligible for coverage. A complete and signed application along with a valid Certificate of Registered Domestic Partnership must be submitted within 31 days of the date the Declaration of Domestic Partnership is registered. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you file an Affidavit of Domestic Partnership with the Participating District while you are enrolled in the Plan, your Unregistered Domestic Partner and his or her children are for coverage. A complete and signed application along with a copy of the Affidavit of Domestic Partnership must be submitted within 31 days of the date the Affidavit of Domestic Partnership is filed.

Your newborn child or your enrolled dependent's newborn child will be covered for 31 days after birth. The enrolled employee must submit a complete and signed application, to the Participating District's payroll or personnel office within 60 days listing the new child as a dependent. If the Participating District does not receive the application, coverage for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

Adopted children are covered for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be covered for the first 31 days from the date of placement. The enrolled employee must submit a complete and signed application, to the Participating District's payroll or personnel office, along with the placement or adoption paperwork within 60 days listing the child as a dependent.

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

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

Enrollment

This section explains how to enroll in the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want covered within 31 days of when you become eligible to apply for coverage. Employees become eligible to apply on the date of hire or the end of any required waiting period. File the application with the Participating District's payroll or personnel office.

You must notify your School District whenever you change your address.

SPECIAL ENROLLMENT

A. Loss of Other Coverage

If you decline coverage for yourself or your dependent(s) when initially eligible because of other dental coverage, you may enroll yourself or your dependent(s) in this Plan outside of the open enrollment period, but only if you satisfy the following criteria:

- You or your dependent(s) were covered under a group dental plan or had dental coverage at the time coverage was previously offered to you;
- You stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined;
- Previous coverage for you or your dependent(s) ended;
- You request such enrollment not later than 31 days after the previous coverage ended.

The following individuals may enroll during the special enrollment period:

- You, the current employee, who lose other coverage;
- Your enrolled dependent who loses coverage under the other plan;
- You, the current employee, and your dependent if neither is enrolled under the Plan, and either loses coverage under the other plan.

To enroll yourself or your dependent you will need to submit a complete and signed application.

B. Enrolling New Dependents

You may obtain coverage for newly acquired or newly eligible dependents by submitting a complete and signed application, to the Participating District's payroll or personnel office within 31 days of their eligibility; when applicable, a marriage certificate, a copy of the registered Declaration of Domestic Partnership, a copy of the filed Affidavit of Domestic Partnership. Enrollment must be submitted within 60 days for newborn children and an adopted child or child placed for adoption

You must notify your School District if family members are added or dropped from coverage, even if it does not affect your premiums.

OPEN ENROLLMENT

If you do not enroll yourself and/or your eligible dependents within 31 days (60 days for newborn children and an adopted child or a child placed for adoption) of first becoming eligible, you will be considered a "late enrollee" and must wait for the next Open Enrollment period to enroll. Open Enrollment occurs once a year at renewal. Late Enrollees have a 12-month waiting period; and are only eligible for Class I – Preventive Services during the first 12 continuous-months of enrollment. Late Enrollees have a 12-month waiting period for orthodontic services.

WHEN COVERAGE BEGINS

Coverage will begin for you and any enrolled dependents on the first day of the month following your Participating District's waiting period.

Coverage for new dependents through marriage will begin on the first day of the month if the marriage date is the first day of the month. Otherwise, coverage begins on the first day of the month following the date of marriage.

Coverage for new dependents through the registration of a Declaration of Domestic Partnership under the Oregon Family Fairness Act will begin the first day of the month if the Declaration of Domestic Partnership is registered the first day of the month. Otherwise, coverage begins the first day of the month following the date the Declaration of Domestic Partnership is registered.

Coverage for new dependents through the filing of an Affidavit of Domestic Partnership with the Participating District will begin on the first day of the month if the Affidavit of Domestic Partnership is filed on the first day of the month. Otherwise, coverage begins the first day of the month following the date the Affidavit of Domestic Partnership is filed.

When the 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 date specified by the court order.

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

If you apply for coverage as a late enrollee, coverage will begin for you and/or your dependents on the date we specify with the acceptance of your application. All other Plan provisions will apply.

WHEN COVERAGE ENDS

A. Termination by Enrolled Employee

You may terminate your coverage, or coverage for any enrolled dependent, by giving us written notice through OEBB. Coverage will end on the last day of the month through which premiums are paid. If you terminate your own coverage, coverage for your dependents also ends at the same time.

B. Death

If you die, coverage for your enrolled dependents ends on the last day of the month in which your death occurs. Note that your enrolled dependents may extend their coverage for up to three years if the requirements for continuation of coverage are met (see page 36 for details). OEBB must notify us of any continuation of coverage, and appropriate premiums must be paid along with OEBB's regular monthly payment.

C. Loss of Eligibility

If your employment terminates, your coverage will end for you and all enrolled dependents on the last day of the month in which termination occurs, or as determined through a collective bargaining agreement, unless you choose to continue coverage as provided under this Policy (see page 32 for details).

D. Loss of Eligibility by Dependent

An enrolled child will lose eligibility when he or she no longer meets the requirements to qualify as a dependent as described on page 8 or when the enrolled employee is no longer legally required to provide coverage for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 32).

Coverage ends for an enrolled Spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced Spouse continues coverage as provided under this Plan (see page 32).

Coverage ends for a Registered Domestic Partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered, unless the former Registered Domestic Partner continues coverage as provided under this Plan (see page 32).

Coverage ends for an Unregistered Domestic Partner 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 Participating District, unless the former Unregistered Partner continues coverage as provided under this Plan (see page 32).

E. Rescission by Insurer

We may rescind your coverage, and/or the coverage of your enrolled dependents, back to your effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by you or your enrolled dependents. As used herein, fraud, material misrepresentation, or concealment may include, but is not limited to, enrolling ineligible individuals on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. We reserve the right to retain premiums paid by you as liquidated damages, and you shall be responsible for the full balance of any benefits paid. Should we terminate coverage under this section, we may, to the extent permitted by law, deny future enrollment of you and your dependents under any Oregon Dental Service policy or contract or the contract of any of our affiliates.

Important Note: The following sections on Family and Medical Leave and Leave of Absence may apply to you. Please check with your Participating District's benefits manager to find out whether you qualify for this coverage.

F. Family and Medical Leave

If the Participating District grants you a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA), the following rules will apply:

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave.
- If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to re-enroll in the Plan on the date you return from leave. To re-enroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the policy will resume at the time of re-enrollment as if there had been no lapse in coverage. You will not have to re-serve any eligibility waiting period under the Plan.
- Your rights under FMLA will be governed by that statute and its regulations.

G. Leave of Absence

If you are granted a non-FMLA leave of absence by the Participating District, you may continue coverage for up to 3 months. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Participating District at your request during which you are still considered to be employed and are carried on the employment records of the Participating District. A leave can be granted for any reason acceptable to the Participating District, including disability and maternity.

H. Other

See "Continuation of Dental Coverage" section starting on page 32.

Benefits and Limitations

Below is a general list of services your dental care program covers when performed by a dental provider (licensed dentist, certified denturist or registered hygienist). These services are covered 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). A panel of dentists shall determine these standards.

Covered dental services are outlined in 4 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, **please see below. Also, see page 24 for exclusions**.

Deductible: $25.00
Per enrollee per plan year or portion thereof
Deductible applies to covered Class II, Class III, and Class IV services

Maximum Payment limit: $1,500.00
Per enrollee per plan year, or portion thereof
All covered services (Class I, II, III, IV) apply to Maximum Payment Limit

Preventive Care

I. Class I: 100% is provided toward covered Class I services

A. Diagnostic
Examination
Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:
1. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period*.
2. Complete series x-rays or a panoramic film is covered once in any 3-year period*.
3. Supplementary bitewing x-rays are covered once in any 6-month period*.
4. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
5. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.

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

Preventive Limitations:
1. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*†.

†Additional cleaning benefit is available for enrollees with diabetes and female enrollees in their third trimester of pregnancy. To be eligible for this additional benefit, enrollees must be enrolled in the Oral Health, Total Health program. See page 21 for more details.

2. Topical application of fluoride is covered once in any 6-month period* for all ages.
3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
4. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for enrollees age 14 or over are not covered.

*Please Note:
These time periods are calculated from the previous date of service.

Restorative Services

II. Class II: 80% is provided toward covered Class II services

A. Restorative

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

Restorative Limitations:

1. Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. **If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.**
2. Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
3. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
4. Refer to Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
5. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

B. Oral Surgery

Extractions (including surgical), other minor surgical procedures, general anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

Oral Surgery Limitations:

1. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
2. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.

3. Surgery on larger lesions or malignant lesions is not considered minor surgery.
4. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

C. Endodontic

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

Endodontic Limitations:

1. A separate charge for cultures is not covered.
2. Pulp capping is covered only when there is exposure of the pulp.
3. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

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

Periodontic Limitations:

1. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
2. Coverage for periodontal maintenance procedure or prophylaxis (cleaning) is limited to once in any 6-month period.
3. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

Major Dental Care

III. Class III: 80% is provided toward covered Class III services

A. Restorative

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

Restorative Limitations:

1. Cast restorations (including pontics) are covered once in a 5-year period on any tooth. See Class II for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

IV. Class IV: 50% is provided toward covered Class IV services

A. Prosthodontic

Implants, bridges, partial dentures, and complete dentures. Includes denture relines and repair of an existing prosthetic device.

Prosthodontic Limitations:

1. A bridge or denture (full or partial denture) will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 5 years.
2. *Full, immediate and overdentures:* If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
3. *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 enrollees 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 abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4. *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 will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
5. Tissue conditioning is covered no more than twice per denture in a 36-month period.
6. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. We will also benefit:

    - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period;
    - 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. The frequency limitation for prosthetic devices will apply to this alternate benefit (only once in any 5-year period); or
    - The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 5-year period;
    - Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
    - 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 5 years.

7. Fixed bridges or removable cast partial dentures are not covered for enrollees under age 16.
8. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

V. General Limitation – Optional Services

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

VI. Non-Participating Dental Providers

The program requires that amounts payable for services of a Non-participating Dental Provider be limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's Non-participating Dentist allowance.

Oral Health, Total Health Program

Did you know that visiting your dentist on a regular basis and keeping your mouth healthy is critical to keeping the rest of your body healthy?

Recent studies have indicated a relationship between periodontal disease, bacteria in the mouth, and various health problems. These problems can include pre-term, low birth weight babies and diabetes. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

ORAL HEALTH, TOTAL HEALTH BENEFITS

We care about your overall health and have developed a program for ODS enrollees based on this new evidence. To be eligible for the additional benefits described in this section, enrollment in the Oral Health, Total Health program is required.

A. Diabetes

If you have diabetes, elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases your risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make your diabetes more difficult to manage. Infections may cause your blood sugar to rise and require more insulin to keep it under control.

Diabetic enrollees covered under this Policy are eligible for a total of 4 prophylaxes (cleanings) or periodontal maintenance sessions per plan year. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

Enrolling in the Oral Health, Total Health program is easy. To enroll, please complete and return the Oral Health, Total Health enrollment form along with proof of diabetes diagnosis. The enrollment form can be accessed on our website or by calling ODS Dental Customer Service at 503-265-2910 or 1-866-923-0410.

B. Pregnancy

Keeping your mouth healthy during your pregnancy is important for you and your 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. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby.

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during your third trimester of pregnancy. By enrolling in the Oral Health, Total Health program, you are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

Enrolling in the Oral Health, Total Health program is easy. To enroll, please contact ODS Dental Customer Service at 503-265-2910 or 1-866-923-0410 or complete and return the Oral Health, Total Health enrollment form found on our website.

Orthodontic Benefit

Orthodontic services are a benefit for you and your enrolled dependents.

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

This Plan will pay **80%** of the participating orthodontist's allowed fee for orthodontic services, up to the maximum benefit. The amount payable to a non-participating orthodontist will be the lesser of 80% of the orthodontist's fees or 80% of the median fee of all participating orthodontists' filed fees with ODS.

The lifetime maximum amount ODS will pay for orthodontic services for an enrollee is $1,500.00. This lifetime maximum is not included in the dental policy maximum.

Late Enrollees have a 12-month waiting period for orthodontic services.

If the dental Policy has a deductible, it does not apply to orthodontic services.

LIMITATIONS

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

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

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

4. If treatment began before the enrollee was eligible under this Policy, ODS will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.

2. The Plan does not cover:

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

3. The following are not covered:

    - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
    - Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
    - Services which are provided, without cost to the enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Policy;
    - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, are excluded.

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

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

6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

7. Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.

8. Gnathologic recordings or similar procedures are excluded.

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

10. Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs are excluded.

11. Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment are excluded.

12. Charges for missed or broken appointments are excluded.

13. Experimental procedures or supplies are excluded.

14. This plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III and Class IV services which were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after individual eligibility ends. This provision is not applicable if the Participating District transfers the plan to another carrier.

15. This plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.

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

17. Claims submitted more than 15 months after the date of service are not covered, except as stated in the Claim Submission section on page 41.

18. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.

19. Services performed on the tongue, lip or cheeks are not covered.

20. Precision attachments are not covered.

21. Taxes.

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

23. Services and supplies for treatment of illness or injury for which a third party is or may be responsible are not covered. (See page 43 for complete details).

24. Benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, are not payable under this Plan when such contract or insurance is issued to, or makes benefits available to, you or your enrolled dependent, whether or not application is duly made therefore (See page 45 for complete details).

25. Vizilite is excluded.

Example of How the Plan Pays

Please note the payments on specific claims will be based on the individual agreement between ODS and the dentist. If you see a Participating Dentist your responsibility may be lower, as some disallowed charges are provider write off, not patient responsibility. For purposes of this example, it is assumed any deductible has been met and the benefit is 80% of the allowed charge. Allowed charge is based on the Maximum Plan Allowance.

Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Co-pay	Paid	Pt. Resp.
1/01/08	D2150 Amalgam Filling	30	$120.00	$20.00*	$0.00	$20.00	$100.00	$20.00	$80.00	$20.00
1/01/08	D9215 Local Anesthesia	--	$50.00	$50.00**	$0.00	$50.00	$0.00	$0.00	$0.00	$0.00
Totals:	---	---	$170.00	$70.00	$0.00	$70.00	$100.00	$20.00	$80.00	$20.00

Reason Code: * THE FEE CHARGED EXCEEDS THE MAXIMUM ALLOWANCE
** A SEPARATE, ADDITIONAL PAYMENT IS NOT PROVIDED FOR LOCAL ANESTHESIA.

Total Out of Pocket Expense

Non-Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Co-pay	Paid	Pt. Resp.
1/01/08	D2150 Amalgam Filling	30	$120.00	$20.00*	$0.00	$0.00	$100.00	$20.00	$80.00	$40.00
1/01/08	D9215 Local Anesthesia	--	$50.00	$50.00**	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00
Totals:	---	---	$170.00	$70.00	$0.00	$0.00	$100.00	$20.00	$80.00	$90.00

Reason Code: * THE FEE CHARGED EXCEEDS THE MAXIMUM ALLOWANCE.
** A SEPARATE, ADDITIONAL PAYMENT IS NOT PROVIDED FOR LOCAL ANESTHESIA.

Total Out of Pocket Expense

The amount you would save, in this example, by seeing a Participating Dentist is $70.00

Coordination of Benefits

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

DEFINITIONS

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

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

Plan includes:

- Group insurance contracts and group-type contracts;
- DHMO (Dental Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Medicare supplement policies;
- Medicaid policies; or
- 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 two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

Complying Plan is a plan that complies with 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.

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

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any Plan covering the claimant. When a Plan provides benefits in the form of a service rather than 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 claimant 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 claimant is not an Allowable Expense.

The following are examples of expenses that are **not** Allowable Expenses:

- The amount of the reduction by the primary Plan because a claimant has failed to comply with the Plan provisions concerning second opinions or prior authorization of services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two 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;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one Plan that calculates its benefits or services 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 or services 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 or service 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 contract 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 contract providing dental benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a Plan that provides dental benefits 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 plan year excluding any temporary visitation.

HOW COB WORKS

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s). The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits.

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(s) that pay(s) 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.
If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan shall provide benefits as if it were the primary Plan when a covered person uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

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:

- If this Plan is primary, it will provide its benefits first.
- 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.
- If the non-complying plan reduces its benefits so that the covered person receives less in benefits than s/he 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 ODS 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 covered person against the non-complying plan.

WHICH PLAN PAYS FIRST?

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a Plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that Plan will determine its benefits before a Plan which covers the person as a dependent.
2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the Plan of the parent whose birthday falls earlier in the plan 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'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
   - 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.

- 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 has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
- If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
  - The Plan covering the custodial parent;
  - The Plan covering the Spouse or Partner of the custodial parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the Spouse or Partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

4. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the first applicable provision (# 2 or #3) above shall determine the order of benefits as if those individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
5. **Active/Retired or Laid Off Employee.** The Plan that covers a claimant as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a Plan that covers a claimant 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
6. **COBRA or State Continuation Coverage.** If a claimant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering that claimant as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
7. **Longer/Shorter Length of Coverage.** The plan that covered an employee, member, subscriber, or retiree (non-dependent) longer is the primary Plan and the Plan that covered the claimant for the shorter period of time is the secondary Plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
8. **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 had it been the primary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. 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 may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

In addition, 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 a claimant is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. ODS may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the claimant. ODS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give ODS any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If another Plan makes payments we should have made under this coordination provision, we can reimburse the other Plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Continuation of Dental Coverage

INDIVIDUAL DENTAL EXCHANGE PROGRAM

When you lose coverage there is an individual dental plan available to enrollees who have been covered under an employer-sponsored dental plan for 12 continuous months prior to their termination date. You must be an Oregon resident to enroll and maintain eligibility for this coverage. The Individual Dental Exchange Program is an individual plan and the benefits are not the same as those you have received under your Participating District's group dental plan. You may enroll in this Plan regardless of any other continuation coverage that may be available through your Participating District.

IMPORTANT NOTICE

The following sections on continuation of coverage may or may not apply to you. Please check with your Participating District's benefits manager to find out whether or not you qualify for this coverage. You and your dependents should read the following notices carefully.

OREGON CONTINUATION COVERAGE FOR SPOUSES AND DOMESTIC PARTNERS AGE 55 AND OVER

A. Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group dental insurance policies to offer enrolled Spouses and Registered Domestic Partners the opportunity to request a temporary extension of dental insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation"). OEBB has also elected to extend this coverage to Unregistered Domestic Partners.

55+ Oregon Continuation only applies to employers with 20 or more employees. ODS will provide 55+ Oregon Continuation coverage to those eligible dependents who elect coverage under ORS 743.600 to 743.602, subject to the following conditions:

- Other than the inclusion of Unregistered Domestic Partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
- ODS will not provide 55+ Oregon Continuation coverage for dependents who do not comply with the notice, election, or other requirements outlined below; and
- As the Plan Administrator, OEBB is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEBB fails to notify the eligible Spouse or Registered Domestic Partner or Unregistered Domestic Partner, premiums shall be waived from the date the notice was required until the date notice is received by the Spouse or Registered Domestic Partner or Unregistered Domestic Partner. OEBB shall be responsible for such premiums.

B. Eligibility Requirements For 55+ Oregon Continuation Coverage

If you are the Spouse or Registered Domestic Partner or Unregistered Domestic Partner of the employee, you may elect 55+ Oregon Continuation coverage for yourself and your enrolled dependents if you meet the following requirements:

- You lose coverage because of the death of the employee, dissolution of marriage or domestic partnership with the employee, or legal separation from the employee;
- You are 55 years of age or older at the time of such event; and
- You are not eligible for Medicare.

C. Notice And Election Requirements For 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, or Legal Separation, Termination. Within 60 days of legal separation, the entry of a judgment of dissolution of marriage or registered domestic partnership, or the termination of an unregistered domestic partnership, a legally separated or divorced Spouse, or a legally separated or former Registered or Unregistered Domestic Partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give the Plan Administrator written notice of the legal separation, dissolution, or termination. The notice shall include the mailing address of the legally separated or divorced Spouse or a legally separated or former Registered or Unregistered Domestic Partner seeking coverage.

Notice of Death. Within 30 days of the death of the employee whose surviving Spouse or Registered Domestic Partner or Unregistered Domestic Partner is eligible for 55+ Oregon Continuation, the Participating District shall give the Plan Administrator written notice of the death and the mailing address of the surviving Spouse or Registered Domestic Partner or Unregistered Domestic Partner.

Election Notice. Within 14 days of receipt of the above notice, the Plan Administrator shall provide notice to the surviving, legally separated or divorced Spouse or the surviving, legally separated or former Registered or Unregistered Domestic Partner, that coverage can be continued, along with an election form. If the Plan Administrator fails to notify the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, within the required 14 days, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, must return the election form within 60 days after the Plan Administrator mails it. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

D. Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current employee. The first premiums shall be paid by the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, to the Participating District within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

E. When 55+ Oregon Continuation Coverage Ends

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

- The failure to pay premiums when due, including any grace period allowed by the Policy;
- The date that the Plan terminates, unless a different group policy is made available;
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes insured under any other group dental plan;

- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, remarries or registers another domestic partnership under the Oregon Family Fairness Act, or files another Affidavit of Domestic Partnership, and becomes covered under another group dental plan; or
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes eligible for Medicare.

COBRA CONTINUATION COVERAGE

A. Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of this section, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the enrolled employee (or retired employee), the enrolled employee's Spouse, and the dependent children of the enrolled employee. Specific qualifying events are listed below.

ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

- Other than the inclusion of Registered and Unregistered Domestic Partners, ODS will offer no greater COBRA rights than the COBRA statute requires;
- ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election, or other requirements outlined below; and
- ODS will not provide COBRA coverage if the Participating District or Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the Participating District or Plan Administrator otherwise fails to comply with any of the requirements outlined below.

B. Qualifying Events

Employee As an employee covered by this Plan, you may elect continuation coverage if you lose coverage because of termination of employment (other than termination for gross misconduct on your part, which may include, but is not limited to, misrepresenting immigration status to obtain employment), or a reduction in hours.

Spouse If you are the Spouse of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for any of the following four qualifying events:

- The death of your Spouse;
- The termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with the Participating District;
- Divorce or legal separation from your Spouse; or
- Your Spouse becomes entitled to Medicare.

(Also, if an employee eliminates coverage for his or her Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

Domestic Partners. A Registered or Unregistered Domestic Partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under this plan, the Registered or Unregistered Domestic Partner would have the same rights to COBRA continuation coverage as a Spouse does, unless otherwise stated. Where this section refers to divorce or legal separation, termination of an Affidavit of Domestic Partnership for Unregistered Domestic Partners or dissolution of a registered domestic partnership under the Oregon Family Fairness Act for Registered Domestic Partners would also apply.

Children A dependent child of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, has the right to continuation coverage if coverage is lost for any of the following five qualifying events:

- The death of the employee parent;
- The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in an employee parent's hours of employment with the Participating District;
- Parents' divorce or legal separation;
- Employee parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the Plan.

C. Other Coverage

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

D. Notice and Election Requirements

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (Spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group for the plan; 2) the name and social security number of the Enrollee(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) 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 timely given, continuation coverage will not be available.

Election Notice. When the Plan Administrator receives a timely Qualifying Event Notice, you, your Spouse, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, you, your Spouse and dependent children will be notified by the Plan 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 employee's termination of employment (other than for gross misconduct), reduction in hours, death of the employee, or the employee's becoming entitled to Medicare.

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

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

E. COBRA Premiums

If you are eligible for continuation coverage, you do not have to show that you are insurable. However, under the law, you are responsible for all premiums for continuation coverage. Your first payment for continuation coverage is due within 45 days after you provide notice of electing coverage (this is the date your election notice is postmarked, if mailed, or the date your election notice is received by the Plan Administrator if hand delivered). This payment must include the amount necessary to cover all months that have ended between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, you will have a grace period of 30 days to pay the premiums. If you do not pay the applicable premiums, in good funds, when due, your continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

F. Length of Continuation Coverage

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

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued only for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to an employee's death, divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the Plan, or coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) 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 enrolled employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

G. Extending the Length of COBRA Coverage

If you elect COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from an enrolled employee's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the enrolled employee's termination of employment or reduction of hours 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 qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the enrolled employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the enrolled employee's termination or reduction of hours.

You must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the enrolled employee's termination of employment or reduction of hours, 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 the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan 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 dependent 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 enrolled employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of an enrolled employee, divorce or legal separation from the enrolled employee, or a dependent 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 qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when an enrolled employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the Plan 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 an employee's Spouse or Registered or Unregistered Domestic Partner age 55 and older who loses coverage due to the employee's death, or due to legal separation, dissolution of marriage or registered domestic partnership, or termination of an unregistered domestic partnership. See page 32 for details.

H. Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the enrolled employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The employee or a family member must notify the Participating District within 31 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Participating District in a timely fashion, the child will not be eligible for continuation coverage.

I. Special Enrollment and Open Enrollment

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

J. When Continuation Coverage Ends

This notice shows the maximum period of COBRA coverage available to the qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premiums are not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group dental plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Group ceases to provide any group dental plan for its employees; or
- during a disability extension period (the disability extension is explained above), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

If you have any questions about COBRA, please contact the Plan Administrator. Please notify the Plan Administrator if you or your Spouse have changed addresses.

K. Trade Act Of 2002

This COBRA provision applies only to employees who have lost their jobs or had a reduction in hours as a result of import competition or shifts of production to other countries.

Second Election Period for Certain Trade-Displaced Individuals. Certain enrolled employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Enrolled employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

- They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- They must have lost group dental plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and
- They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

The special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which a TAA Eligible Employee began receiving a trade readjustment allowance (or would have become eligible for such an allowance but for the requirement to exhaust unemployment compensation) or began receiving alternative trade adjustment assistance, but only if the election is made within 6 months after the initial loss of group dental plan coverage that occurred in connection with the TAA Eligible Employee's termination of employment.

Duration of COBRA Coverage Elected During the Special Second Election Period. COBRA coverage elected during the special second election period is not retroactive. Coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

COBRA Tax Credit. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premium paid for qualified dental insurance coverage, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if an employee is called to active duty by any of the armed forces of the United States of America. However, if an employee requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if you pay any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If an employee does not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

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

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

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

Claims Administration and Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A. Claim Submission

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. Send your claim to:

The ODS Companies
601 S.W. Second Avenue
Portland, Oregon 97204

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than one year from the date submission is otherwise required. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the previous paragraph.

B. Explanation of Benefits (EOB)

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

If you do not receive an Explanation of Benefits within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained under Submission and Payment of Claims.

C. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at 503-265-2910 or toll-free at 1-866-923-0410 or write to our Dental Customer Service Department. We will respond to your inquiry within 30 days of receipt.

GRIEVANCE AND APPEALS

A. Grievance

Complaint means an expression of dissatisfaction about a specific problem you have encountered or about a decision by an insurer or an agent acting on behalf of ODS, and which includes a request for action to resolve the problem or change the decision. A complaint does not include an inquiry.

Grievance means a written complaint submitted by you or on your behalf regarding:

- Availability, delivery, or quality of healthcare services, including a complaint regarding an adverse determination made pursuant to a utilization review;
- Claims payment, handling, or reimbursement for healthcare services; or
- Matters pertaining to the contractual relationship between you and ODS.

Inquiry means a written request for information or clarification about any subject related to your health benefit plan. An inquiry does not in itself constitute a complaint.

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

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

If you have a **grievance**, you must submit it in writing to ODS and ask for a review. If you need assistance on filing a grievance, contact ODS Dental Customer Service at 503-265-2910 or toll-free at 1-866-923-0410, to discuss the issue as it may be possible to resolve it with a phone call. We will acknowledge receipt of the written grievance within seven (7) days of receipt and conduct an investigation. We will inform you of the results of the investigation and any action we intend to take within 30 days of receiving the grievance. If more time is needed, we will issue a notice of delay, and complete the investigation within an additional 15 days (i.e., 45 days from the date we receive the grievance).

Claims Grievances:
If you disagree with a decision made regarding coverage of services (denial of benefits received, or a disagreement on amount of benefits), your grievance must be filed within 60 days of the date of our action on your claim (the date on the Explanation of Benefits provided upon action/payment for the claim at issue). Claims grievances filed outside the 60-day limit will not be considered.

B. Appeals

If you disagree with our decision made in response to a grievance, you may appeal the decision. ODS has a two level formal appeal process. Your appeal must be made within 60 days of the date of our action on your initial grievance. You may also call our Dental Customer Service Department at 503-265-2910 or toll-free at 1-866-923-0410, to discuss the issue as it may be possible to resolve it without filing a formal appeal.

First Level Appeal If you request a First Level Appeal, you must submit your appeal in writing along with any additional relevant information you wish to submit. ODS will acknowledge receipt of a written appeal, in writing, within 7 days. ODS will conduct an investigation by persons who were not involved in the review of your grievance. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, we will send you a written notice of the decision on your appeal, including the basis for the decision. If applicable, the notice will include information on your right to a Second Level of Appeal.

Second Level Appeal If you are still dissatisfied after the First Level Appeal, you may request a Second Level Appeal by persons who were not involved in the review of the grievance or First Level Appeal. You must submit your second appeal in writing within 60 days of the date of our action on your First Level Appeal. ODS will acknowledge receipt of a written appeal, in writing, within seven days and conduct an investigation. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, ODS will notify you in writing of the decision.

You have the option to appear before the panel in person or by conference call or other appropriate technology. ODS will allow your representative to act on your behalf in the appeal process if you choose. Your appeal will be reviewed within 23 calendar days of its receipt and a written decision will be sent to you within seven calendar days after the decision is made.

C. Additional Enrollee Rights

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By calling:	(503) 947-7984
By writing:	Oregon Insurance Division Consumer Protection Unit 350 Winter Street NE, Room 440-2 Salem, Oregon 97310
By internet	http://www.cbs.state.or.us/external/ins/

Information included in the "Additional Enrollee Rights" is subject to change upon notice from the Director of the Oregon Insurance Division.

BENEFITS AVAILABLE FROM OTHER SOURCES

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

A. Coordination of Benefits (COB)

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

B. Third-Party Liability

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

Because recovery from a Third Party may be difficult and take a long time, and payment of benefits where a Third Party may be legally liable is excluded under the terms of this Plan/Coverage, as a service to you, we will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor our rights of subrogation as discussed below, and, if requested by us, to reimburse us in full from any recovery the Covered Individual may receive, no matter how the recovery is characterized.

Upon claiming or accepting Benefits, or the provision of Benefits, under the terms of this Plan/Coverage, the member agrees that we shall have the remedies and rights as stated in this Section. We may elect to seek recovery under one or more of the procedures outlined in this Section. The Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

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

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

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

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

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

Recovery Funds means any amount recovered from a Third Party.

Subrogation
Upon payment by the Plan/Coverage, we shall be subrogated to all of the Covered Individual's rights of recoveries therefore, and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this sub-section, we may pursue the Third Party in our own name, or in the name of the member. We are entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan/Coverage.

Right of Recovery
In addition to our subrogation rights, we may, at our sole discretion and option, ask that the Covered Individual, and his or her attorney, if any, protect our reimbursement rights. If we elect to proceed under this sub-section, the following rules apply:

1. The Covered Individual holds any rights of recovery against the Third Party in trust for us, but only for the amount of Benefits we paid for that illness or injury.

2. We are entitled to receive the amount of Benefits we have paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, we are entitled to receive the amount of Benefits we have paid whether the healthcare expenses are itemized or expressly excluded in the Third Party recovery.

3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect our reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to us, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section we will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

5. This right of recovery includes the full amount of the Benefits paid, or pending payment by us, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. Our recovery rights will not be reduced due to the Covered Individual's own negligence.
6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Motor Vehicle Accidents
Any expense for injury or illness which results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered Benefit under this Plan/Coverage and will not be paid by us.

If a claim for health care expenses arising out of a motor vehicle accident is filed with us, and if motor vehicle insurance has not yet paid, then we may advance Benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, and subject to the next paragraph.

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, in Third Party claims involving the use or operation of a motor vehicle, we, at our sole discretion and option, are entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

Additional Third Party Liability Section Provisions
In connection with our rights to obtain reimbursement, or to exercise our right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following, and agree that we may do one or more of the following, at our discretion:

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

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

3. In order to receive an advance payment of Benefits pursuant to this Section, we require that any Covered Individual seeking payment of Benefits by us, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Individual's parent or guardian, must fill out, sign and return to our office a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.

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

    - Sign and deliver such documents as we reasonably require to protect our rights;
    - Provide any information to us relevant to the application of the provisions of this Section, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
    - Take such actions as we may reasonably request to assist us in enforcing our rights to be reimbursed from Third Party recoveries.

5. By accepting the payment of benefits by us, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.

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

7. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.

8. This Section applies to any Covered Individual for whom advance payment of Benefits is made by us whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by us.

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

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

11. Coordination of Benefits (where the Covered Individual has dental/medical coverage under more than one Plan or dental/medical insurance policy) is not considered a Third Party Claim.

12. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

Miscellaneous Provisions

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

REQUEST FOR INFORMATION

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

DISCLOSURE OF BENEFIT REDUCTION

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

CONFIDENTIALITY OF ENROLLEE INFORMATION

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

TRANSFER OF BENEFITS

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

RECOVERY OF BENEFITS PAID BY MISTAKE

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

PLAN PROVISIONS

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

WARRANTIES

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

LIMITATION OF LIABILITY

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

PROVIDER REIMBURSEMENTS

Under state law, providers contracting with ODS to provide services to enrollees agree to look only to ODS for payment of the part of the expense which is covered by the Plan and may not bill the enrollee in the event ODS fails to pay the provider for whatever reason. The provider may bill the enrollee for applicable co-payments and deductibles or non-covered expenses except as may be restricted in the provider contract.

INDEPENDENT CONTRACTOR DISCLAIMER

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

NO WAIVER

Any waiver of any provision of this Plan, or any performance under this 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. No delay or omission on the part of ODS in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

GROUP IS THE AGENT

OEBB is your and your enrolled dependents' agent for all purposes under this Plan. OEBB is not the agent of Oregon Dental Service.

GOVERNING LAW

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

WHERE ANY LEGAL ACTION MUST BE FILED

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

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this Plan and filed against us by you, any of your dependents, any enrollee or any third party, must be filed in court within 3 years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

THE ODS COMPANIES

601 S.W. Second Avenue
Portland, OR 97204
www.odscompanies.com

MEMBER INQUIRIES

Portland: 503-265-2910
Toll-Free: 1-866-923-0410
TDD/TTY: 1-800-433-6313
(for the hearing and speech impaired)

Spanish Dental Customer Service
(Servicio al Cliente de Cuidados Dental)

Portland: 503-265-2963
Llamado Gratis: 1-877-299-9063

ODSDENTBK 4-1-2008

Member handbooks and other services are available at **www.odscompanies.com.**
Insurance products provided by ODS Health Plans, Inc.

DELTA DENTAL®