



## GROUP DENTAL PLAN

**City of Springfield**

High Option Plan

Delta Dental Premier Plan

Effective Date: January 1, 2013

Group No. 10001700

[www.odskompanies.com](http://www.odskompanies.com)



Member handbooks and more are available at [www.odskompanies.com](http://www.odskompanies.com)

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## TABLE OF CONTENTS

<b>SECTION 1.</b>	<b>WELCOME.....</b>	<b>2</b>
<b>SECTION 2.</b>	<b>USING THE PLAN .....</b>	<b>3</b>
2.1	MEMBER RESOURCES .....	3
<b>SECTION 3.</b>	<b>DEFINITIONS .....</b>	<b>4</b>
<b>SECTION 4.</b>	<b>BENEFITS AND LIMITATIONS .....</b>	<b>8</b>
4.1	CLASS I:.....	8
4.1.1	Diagnostic.....	8
4.1.2	Preventive .....	9
4.2	CLASS II: .....	9
4.2.1	Restorative .....	9
4.2.2	Oral Surgery.....	10
4.2.3	Endodontic.....	10
4.2.4	Periodontic .....	10
4.2.5	Anesthesia .....	11
4.3	CLASS III:.....	11
4.3.1	Restorative .....	11
4.4	CLASS IV: .....	11
4.4.1	Prosthodontic .....	11
4.5	GENERAL LIMITATION – OPTIONAL SERVICES .....	12
4.6	NON-PARTICIPATING DENTISTS.....	13
<b>SECTION 5.</b>	<b>ORAL HEALTH, TOTAL HEALTH PROGRAM .....</b>	<b>14</b>
5.1	ORAL HEALTH, TOTAL HEALTH BENEFITS.....	14
5.1.1	Diabetes.....	14
5.1.2	Pregnancy.....	14
5.1.3	How to Enroll .....	14
<b>SECTION 6.</b>	<b>EXCLUSIONS .....</b>	<b>15</b>
<b>SECTION 7.</b>	<b>ELIGIBILITY .....</b>	<b>18</b>
7.1	SUBSCRIBER.....	18
7.2	RETIREEES .....	18
7.3	DEPENDENTS .....	18
7.4	QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO).....	19
7.5	NEW DEPENDENTS.....	19
<b>SECTION 8.</b>	<b>ENROLLMENT .....</b>	<b>20</b>
8.1	ENROLLING ELIGIBLE EMPLOYEES .....	20
8.2	ENROLLING NEW DEPENDENTS.....	20
8.3	OPEN ENROLLMENT.....	20
8.4	SPECIAL ENROLLMENT RIGHTS .....	20
8.4.1	Loss of Other Coverage.....	20
8.4.2	Eligibility for Premium Subsidy .....	21
8.4.3	New Dependents .....	21
8.5	WHEN COVERAGE BEGINS .....	21

8.6	WHEN COVERAGE ENDS .....	22
8.6.1	Termination of the Group Plan .....	22
8.6.2	Termination by Subscriber .....	22
8.6.3	Death .....	22
8.6.4	Termination, Layoff or Reduction in Hours of Employment .....	22
<b>8.6.6</b>	<b>Eligible Retirees</b> .....	<b>23</b>
8.6.7	Loss of Eligibility by Dependent .....	23
8.6.8	Rescission by the Plan .....	23
8.6.9	Continuing Coverage .....	23
<b>SECTION 9.</b>	<b>CLAIMS ADMINISTRATION &amp; PAYMENT</b> .....	<b>24</b>
9.1	SUBMISSION AND PAYMENT OF CLAIMS .....	24
9.1.1	Claim Submission .....	24
9.1.2	Explanation of Benefits (EOB).....	24
9.1.3	Claim Inquiries .....	24
9.2	APPEALS.....	24
9.2.1	Definitions .....	24
9.2.2	Time Limit for Submitting Appeals .....	25
9.2.3	The Review Process .....	25
9.2.4	First Level Appeals .....	25
9.2.5	Second Level Appeal .....	25
9.3	BENEFITS AVAILABLE FROM OTHER SOURCES.....	26
9.3.1	Coordination of Benefits (COB).....	26
9.3.2	Third Party Liability .....	26
<b>SECTION 10.</b>	<b>COORDINATION OF BENEFITS</b> .....	<b>30</b>
10.1	DEFINITIONS .....	30
10.2	HOW COB WORKS .....	31
10.3	ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?) .....	32
10.4	EFFECT ON THE BENEFITS OF THIS PLAN .....	33
10.5	ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION.....	33
10.6	CORRECTION OF PAYMENTS.....	33
10.7	RIGHT OF RECOVERY .....	34
<b>SECTION 11.</b>	<b>MISCELLANEOUS PROVISIONS</b> .....	<b>35</b>
11.1	REQUEST FOR INFORMATION .....	35
11.2	CONFIDENTIALITY OF MEMBER INFORMATION .....	35
11.3	TRANSFER OF BENEFITS .....	35
11.4	RECOVERY OF BENEFITS PAID BY MISTAKE .....	35
11.5	CONTRACT PROVISIONS .....	35
11.6	WARRANTIES.....	35
11.7	LIMITATION OF LIABILITY.....	36
11.8	PROVIDER REIMBURSEMENTS .....	36
11.9	INDEPENDENT CONTRACTOR DISCLAIMER .....	36
11.10	NO WAIVER .....	36
11.11	GROUP IS THE AGENT .....	36
11.12	GOVERNING LAW .....	36
11.13	WHERE ANY LEGAL ACTION MUST BE FILED .....	37
11.14	TIME LIMITS FOR FILING A LAWSUIT.....	37

<b>SECTION 12.</b>	<b>CONTINUATION OF DENTAL COVERAGE.....</b>	<b>38</b>
12.1	INDIVIDUAL DENTAL EXCHANGE PROGRAM.....	38
12.2	COBRA CONTINUATION COVERAGE.....	38
12.2.1	Introduction.....	38
12.2.2	Qualifying Events .....	38
12.2.3	Other Coverage .....	39
12.2.4	Notice and Election Requirements .....	39
12.2.5	COBRA Premiums .....	40
12.2.6	Length of Continuation Coverage.....	40
12.2.7	Extending the Length of COBRA Coverage .....	40
12.2.8	Newborn or Adopted Child.....	41
12.2.9	Special Enrollment and Open Enrollment .....	42
12.2.10	When Continuation Coverage Ends.....	42
12.3	UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) .....	42
12.4	FAMILY AND MEDICAL LEAVE .....	43
12.5	LEAVE OF ABSENCE .....	43
12.6	STRIKE OR LOCKOUT.....	43
<b>SECTION 13.</b>	<b>EXHIBITS .....</b>	<b>44</b>
13.1	TOOTH CHART – THE PERMANENT ARCH.....	44
13.2	EXAMPLE OF HOW THE PLAN PAYS .....	45

## **SECTION 1. WELCOME**

This handbook describes the main features of the Group's dental plan (the "Plan"), but does not waive any of the conditions of the Plan as set out in the Plan Document.

The Plan is self-funded and the Group has contracted with ODS to provide claims and other administrative services.

Members may direct questions to one of the numbers listed below or access tools and resources on ODS' personalized member website, myODS, at [www.odskompanies.com](http://www.odskompanies.com). myODS is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

ODS  
P.O. Box 40384  
Portland, Oregon 97240

### **Dental Customer Service Department**

Portland 503-265-2965  
Toll Free 888-217-2365

En Español 503-265-2963  
Llamado Gratis 877-299-9063

Relay Service for the Hearing and Speech Impaired

711

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its members 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 all members.

This handbook may be changed or replaced at any time, by the Group, without the consent of any member. All plan provisions are governed by the Group's agreement with ODS. This handbook may not contain every plan provision.

## SECTION 2. USING THE PLAN

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

Members needing dental care may go to any dental office. However, **there are differences in reimbursement for participating Delta Dental Premier dentists and non-participating dentists or dental care providers.** An example is provided in section 13.2. While a member may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

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

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

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

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

### 2.1 MEMBER RESOURCES

**ODS Website** (log in to **myODS**)  
[www.odscompanies.com](http://www.odscompanies.com)

**Dental Customer Service Department**

Portland 503-265-2965; Toll-free 888-217-2365; En Español 503-265-2963; Llamado gratis 877-299-9063

**Telecommunications Relay Service** for the hearing impaired  
711

## SECTION 3. DEFINITIONS

The following are definitions of some important terms used in this handbook.

**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 ODS' 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 Domestic Partnership** means a signed document that attests the subscriber and one other eligible person meet the criteria in the definition of unregistered domestic partner.

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

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

**Anterior** refers to teeth located at the front of the mouth (tooth chart in section 13.1).

**Benefits** means those covered services that are available under the terms of the Plan.

**Bicuspid** is a premolar tooth, between the front and back teeth (tooth chart in section 13.1).

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

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

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

**Claim Determination Period** means a calendar year (January 1 through December 31) or portion thereof.

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

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

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

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

**Dentally Necessary** means services that:

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

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

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

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

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

**Domestic Partner** refers to a registered domestic partner and an unregistered domestic partner as follows:

- a. **Registered Domestic Partner** means a person of the same sex joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.
- b. **Unregistered Domestic Partner** means a person of the same sex who has entered into a partnership with the subscriber that meets the following criteria:

The domestic partner and subscriber

- i. are at least 18 years of age;
- ii. share a close personal relationship and are responsible for each other's welfare;
- iii. are each other's sole domestic partner;
- iv. are not legally married or registered under the laws of any federal, state or local government and have not had a spouse or domestic partner within the prior 6 months. If previously married or registered, the 6 month period starts on the final date of divorce or dissolution of registration;
- v. are not related by blood closer than would bar marriage in the State of Oregon;
- vi. were mentally competent to contract when their domestic partnership began.
- vii. have jointly shared the same regular and permanent residence for at least 6 months; and
- viii. 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.

**Eligible Employee** means any employee or former employee who has met the eligibility requirements to be enrolled under the Plan.

**Enrollment Date** means the date a member's coverage becomes effective under the terms of the Plan.

The **Group** is City of Springfield, the organization that has contracted with ODS to provide claims and other administrative services. It also means the Plan Sponsor.

**Group Eligibility Waiting Period** means the period of employment with the Group that a prospective member must complete before coverage begins.

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

**Implant** is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower 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.

**Maximum Payment Limit** means the amount payable by the Plan for covered services received each calendar year, or portion thereof, for each member.

**Maximum Plan Allowance (MPA)** is the maximum amount that the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with ODS/Delta Dental. For non-participating dentists or dental care providers, the maximum amount is based on a per service average allowance of the participating Delta Dental Premier dentists' filed fees. *The non-participating dentist or dental care provider has the right to bill the difference between ODS' maximum plan allowance and the actual charge. This difference will be the member's responsibility.*

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

**Non-participating Dentist or Dental Provider** means a licensed dental provider who has not agreed to the terms and conditions established by ODS that participating Delta Dental Premier dentists have agreed to.

**ODS** refers to Oregon Dental Service, a not-for-profit dental healthcare service contractor. ODS is the claims administrator of the Plan. References to ODS as paying claims or issuing benefits mean that ODS processes a claim and the Group reimburses ODS for any benefit issued.

**Participating Delta Dental Premier 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.

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

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

The **Plan** is the dental benefit plan sponsored and funded by the Group.

**Plan Sponsor** means the Group.

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

**Posterior** refers to teeth located toward the back of the mouth (tooth chart in section 13.1).

**Prophylaxis** is cleaning and polishing of all teeth.

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

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

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

**Subscriber** means any employee or former employee who is enrolled in the Plan.

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

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

## SECTION 4. BENEFITS AND LIMITATIONS

Below is a general list of services the Plan covers when performed by a dentist or dental care provider (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). ODS' dental consultants and dental director shall determine these standards. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

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

Limitations may apply to these services, and are noted below. See Section 6 for exclusions.

**Deductible:** None

**Maximum payment limit:** \$1,500

Per member per calendar year, or portion thereof

All covered services (Class I, II, III) apply to maximum payment limit

### 4.1 CLASS I:

**COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST CALENDAR YEAR A MEMBER IS COVERED.**

Payment increases by 10% each successive calendar year. To qualify for this increase, the member must visit the dentist at least once during the calendar year. Failure to do so will cause a 10% reduction in payment for the next calendar year, although payment never drops below 70%.

Class I services will be covered at 100% at the end of 3 calendar years, assuming at least one visit to the dentist each of these years.

#### 4.1.1 Diagnostic

a. **Diagnostic Services:**

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

b. **Diagnostic Limitations:**

- i. Periodic (routine) or comprehensive examinations or consultations are covered twice in a 12-month period.
- ii. Complete series x-rays or a panoramic film is covered once in any 5-year period\*.
- iii. Supplementary bitewing x-rays are covered once in a 12-month period.

- iv. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
- v. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.

#### 4.1.2 Preventive

##### a. Preventive Services:

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

##### b. Preventive Limitations:

- i. Prophylaxis (cleaning) or periodontal maintenance is covered twice in a 12-month period †.
- ii. Topical application of fluoride is covered twice in a 12-month period for members age 18 and under. For members age 19 and over, topical application of fluoride is covered twice in a 12-month period if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
- iii. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
- iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

\*These time periods are calculated from the previous date of service.

†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see Section 5).

#### 4.2 CLASS II:

**COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST CALENDAR YEAR A MEMBER IS COVERED.**

Payment increases by 10% each successive calendar year. To qualify for this increase, the member must visit the dentist at least once during the calendar year. Failure to do so will cause a 10% reduction in payment for the next calendar year, although payment never drops below 70%.

Class II services will be covered at 100% at the end of 3 calendar years, assuming at least one visit to the dentist each of these years.

#### 4.2.1 Restorative

##### a. Restorative Services:

- i. Amalgam fillings and composite fillings for the treatment of decay.

- b. **Restorative Limitations:**
  - i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
  - ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
  - iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.3.1.
  - iv. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

#### 4.2.2 Oral Surgery

- a. **Oral Surgery Services:**
  - i. Extractions (including surgical),
  - ii. Other minor surgical procedures.
- b. **Oral Surgery Limitations:**
  - i. A separate, additional charge for alveoplasty done in conjunction with surgical removal of teeth is not covered.
  - ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
  - iv. Brush biopsy is covered twice in a 12-month period. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

#### 4.2.3 Endodontic

- a. **Endodontic Services:**
  - i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).
- b. **Endodontic Limitations:**
  - i. A separate charge for cultures is not covered.
  - ii. Pulp capping is covered only when there is exposure of the pulp.
  - iii. 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.

#### 4.2.4 Periodontic

- a. **Periodontic Services:**
  - i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.
- b. **Periodontic Limitations:**
  - i. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
  - ii. Coverage for periodontal maintenance procedure under Class I, Preventive.
  - iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
  - iv. 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.

#### 4.2.5 Anesthesia

a. **Anesthesia Services:**

- i. General anesthesia or IV sedation in conjunction with covered surgical procedures performed in a dental office.
- ii. General anesthesia or IV sedation when necessary due to concurrent medical conditions.

#### 4.3 CLASS III:

**COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE THE FIRST CALENDAR YEAR A MEMBER IS COVERED.**

Payment increases by 10% each successive calendar year. To qualify for this increase, the member must visit the dentist at least once during the calendar year. Failure to do so will cause a 10% reduction in payment for the next calendar year, although payment never drops below 70%.

Class III covered services will be covered at 100% at the end of 3 calendar years, assuming at least one visit to the dentist each of these years.

#### 4.3.1 Restorative

a. **Restorative Services:**

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

b. **Restorative Limitations:**

- i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 4.2.1 for limitations on buildups.
- ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
- iii. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

#### 4.4 CLASS IV:

**COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE**

There is no "10% increase" provision.

#### 4.4.1 Prosthodontic

a. **Prosthodontic Services:**

- i. Bridges,
- ii. Partial and complete dentures,
- iii. Denture relines,
- iv. Repair of an existing prosthetic device
- v. Implants

a. **Prosthodontic Limitations:**

- i. A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
- ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
- iv. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines 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.
- v. Tissue conditioning is covered no more than twice per denture in a 36-month period.
- vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The Plan will also cover:
  - A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
  - B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or
  - C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period.
  - D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
  - E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.
- vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
- viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

#### **4.5 GENERAL LIMITATION – OPTIONAL SERVICES**

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

#### **4.6 NON-PARTICIPATING DENTISTS**

The amounts payable for services of a non-participating dentist or dental care provider are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating dentist fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance.

## **SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM**

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

### **5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS**

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

#### **5.1.1 Diabetes**

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

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

#### **5.1.2 Pregnancy**

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

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

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

#### **5.1.3 How to Enroll**

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

## **SECTION 6. EXCLUSIONS**

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

### **Anesthesia or Sedation**

General anesthesia and/or IV sedation except as stated in section 4.2.5.

### **Anesthetics, Analgesics, Hypnosis, and Medications**

Including nitrous oxide, local anesthetics or any other prescribed drugs.

### **Benefits Not Stated**

Services or supplies not specifically described in this handbook as covered dental services.

### **Claims Not Submitted Timely**

Claims submitted more than 12 months after the date of service, except as stated in section 9.1.1.

### **Congenital or Developmental Malformations**

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

### **Cosmetic Services**

### **Experimental or Investigational Procedures**

Including expenses incidental to or incurred as a direct consequence of such procedures.

### **Facility Fees**

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

### **Gnathologic Recordings**

### **Illegal Acts, Riot or Rebellion**

Services and supplies for treatment of an injury or condition caused by or arising out of a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or arising directly from an illegal act.

### **Instructions or Training**

Including plaque control and oral hygiene or dietary instruction.

### **Localized Delivery of Antimicrobial Agents**

### **Missed Appointment Charge**

**Never Events**

Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

**Orthodontia****Periodontal Charting****Precision Attachments****Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth**

Including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

**Services on Tongue, Lip, or Cheek****Services Otherwise Available**

Including:

- a. Those compensable under workers' compensation or employer's liability laws;
- b. Those provided by any city, county, state or federal law, except for Medicaid coverage;
- c. Those provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan;
- d. Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the member enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended; or
- e. Those provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan.

**Services Provided by a Relative**

Relatives, for the purpose of this exclusion, include a member or a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

**Taxes****Third Party Liability Claims**

Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes 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, when such contract or insurance is issued to or makes benefits available to a member, whether or not such benefits are requested. (See section 9.3.2).

**TMJ**

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

**Treatment After Coverage Terminates**

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

**Treatment Before Coverage Begins****Treatment Not Dentally Necessary**

Including services:

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

## **SECTION 7. ELIGIBILITY**

The date a person becomes eligible may be different than the date coverage begins (see section 8.5).

### **7.1 SUBSCRIBER**

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

- a. is a permanent documented full time employee, sole proprietor, owner, business partner, or corporate officer of the Group;
- b. is not a seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor;
- c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security;
- d. works for the Group on a regularly scheduled basis at least 30 hours per week; and
- e. satisfies any eligibility waiting period.

Spouses or domestic partners who are both eligible employees may each enroll as a subscriber or one may be covered as an enrolled dependent of the other.

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws.

### **7.2 RETIREES**

Retirees meeting eligibility criteria are also covered.

### **7.3 DEPENDENTS**

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are subject to the Plan's child age limit.

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

- a. A subscriber's natural or adopted child;
- b. The natural or adopted child of a subscriber's spouse or domestic partner;
- c. Children placed for adoption with a subscriber. Adoption paperwork must be provided;
- d. A newborn child of an enrolled dependent for the first 31 days of the newborn's life; and
- e. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided.

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. For the purposes of this handbook, mental incapacity means intellectual competence usually characterized by an IQ of less than 70, and physical incapacity means the inability to pursue

an occupation or education because of a physical impairment. To be eligible, the child must be unmarried and principally dependent on the subscriber for support. The incapacity must have arisen before the child's 26th birthday and the child must have had continuous dental coverage. The subscriber must provide ODS with a written physician's statement that confirms that these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by ODS' medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis except in cases where the disability is certified to be permanent.

#### **7.4 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

The Plan will cover persons 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 an eligible employee who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such eligible employee.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group 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. A copy of such procedures is available from the Group without charge.

#### **7.5 NEW DEPENDENTS**

If a subscriber marries or registers domestic partner, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

If a subscriber files an Affidavit of Domestic Partnership with the Group, the unregistered domestic partner and his or her children are eligible for coverage.

A member's newborn child will automatically be enrolled for 31 days after birth. Adopted children are automatically enrolled for the first 31 days from the date of the adoption decree. If a child is placed with the subscriber pending the completion of adoption proceedings, that child will be enrolled for the first 31 days from the date of placement. To obtain coverage, a complete and signed application must be submitted within those 31 days. If the application is not received, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

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

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply during the first 31 days of coverage for newborn or adopted children.
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## **SECTION 8. ENROLLMENT**

### **8.1 ENROLLING ELIGIBLE EMPLOYEES**

A complete and signed application for the eligible employee and any dependents to be enrolled must be filed within 31 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period and file the application with the Group.

The subscriber must notify the Group and ODS of any change of address.

### **8.2 ENROLLING NEW DEPENDENTS**

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, registered domestic partnership documentation, a copy of the filed Affidavit of Domestic Partnership, or adoption or placement for adoption paperwork must be submitted within 31 days of their eligibility.

The subscriber must notify the Group and ODS if family members are added or dropped from coverage, even if it does not affect premiums.

### **8.3 OPEN ENROLLMENT**

If an eligible employee and/or any eligible dependents are not enrolled within 31 days of first becoming eligible, they will be considered “late enrollees” and must wait for the next open enrollment period to enroll. Open enrollment occurs once a year at renewal. However, an eligible person shall not be considered a late enrollee if he or she meets one of the eligibility requirements described in section 8.4.

### **8.4 SPECIAL ENROLLMENT RIGHTS**

#### **8.4.1 Loss of Other Coverage**

If coverage is declined when initially eligible because of other dental coverage, an eligible employee or any dependent(s) may enroll in the Plan outside of the open enrollment period, but only if the following criteria are met:

- a. The eligible employee or dependent was covered under a group dental plan or had dental coverage at the time coverage was previously offered;
- b. The eligible employee stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined;
- c. The eligible employee requests such enrollment not later than 31 days after the previous coverage ended (except for event iv. below, which allows up to 60 days); and
- d. One of the following events has occurred:
  - i. The eligible employee’s or dependent’s prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; this includes reaching the lifetime maximum while on COBRA coverage.
  - ii. The eligible employee’s or dependent’s prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:

- A. legal separation or divorce;
  - B. loss of dependent status per plan terms;
  - C. death;
  - D. termination of employment;
  - E. reduction in the number of hours of employment;
  - F. reaching the lifetime maximum on all benefits;
  - G. the plan ceasing to offer coverage to a group of similarly situated persons;
  - H. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan;
  - I. termination of the benefit package option, and no substitute option is offered.
- iii. The employer contributions toward the eligible employee's or dependent's other coverage were terminated. (If employer contributions cease, the eligible employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)
  - iv. The eligible employee's or dependent's prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

#### **8.4.2 Eligibility for Premium Subsidy**

If an eligible employee or dependent covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

The special enrollment rights as described in sections 8.4.1 and 8.4.2 apply:

- a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy;
- b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy;
- c. To both the eligible employee and the dependent if neither is enrolled under the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee will need to submit a complete and signed application within the required timeframe.

#### **8.4.3 New Dependents**

An eligible employee and spouse or domestic partner will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, the registration of a domestic partnership or the filing of an Affidavit of Domestic Partnership, birth, adoption, or placement for adoption); however, other existing dependents will not.

### **8.5 WHEN COVERAGE BEGINS**

Coverage will begin on the first day of the month for members becoming eligible to apply on the first day of a month. For members becoming eligible to apply after the first day of a month, coverage begins the first day of the following month.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group begins on the first day of the month if the marriage, registration or filing date is the first day of the month. Otherwise, coverage begins the first day of the month following the date of marriage, registration or filing.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

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

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request.

## **8.6 WHEN COVERAGE ENDS**

There are a variety of circumstances in which a member's coverage will end. These are described in the following sections.

### **8.6.1 Termination of the Group Plan**

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

### **8.6.2 Termination by Subscriber**

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving written notice to the Group. Coverage will end on the last day of the month through which premiums are paid. If a subscriber terminates his or her own coverage, coverage for any dependents also ends at the same time.

### **8.6.3 Death**

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see section 12.2).

### **8.6.4 Termination, Layoff or Reduction in Hours of Employment**

If employment terminates, coverage will end on the last day of the month in which termination occurs, unless a member chooses to continue coverage (see Section 12).

If a subscriber is laid off by the Group and returns to active work within 6 months of being laid off, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 6 months the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the Plan on the date the subscriber qualifies, and coverage will begin on that date provided the necessary premiums for coverage are paid.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

### **8.6.6 Eligible Retirees**

Coverage ends at the end of the month in which the following occurs:

- a. The retiree attains the age of 65;
- b. The enrolled spouse or eligible domestic partner attains the age of 65;
- c. The retiree or a dependent become eligible for Medicare; or
- d. An eligible child attains the age of 26.

Enrolled dependents will continue to be eligible under the Plan regardless of the retiree's status, unless they meet the above criteria.

### **8.6.7 Loss of Eligibility by Dependent**

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), and 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 spouse or registered domestic partner continues coverage as provided under the Plan (see Section 12).

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 Group.

### **8.6.8 Rescission by the Plan**

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by a member, which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. Should the Plan terminate coverage under this section, ODS may, to the extent permitted by law, deny future enrollment of the members under any Oregon Dental Service policy or contract or the contract of any affiliates.

### **8.6.9 Continuing Coverage**

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

## SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

### 9.1 SUBMISSION AND PAYMENT OF CLAIMS

#### 9.1.1 Claim Submission

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

#### 9.1.2 Explanation of Benefits (EOB)

Soon after receiving a claim, ODS will report its action on the claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myODS. The Explanation of Benefits will indicate if a claim has been paid, denied, or accumulated toward satisfying the deductible, if any. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 9.1.1.

#### 9.1.3 Claim Inquiries

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

### 9.2 APPEALS

#### 9.2.1 Definitions

For purposes of section 9.2, the following definitions apply:

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

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

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

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

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

### **9.2.2 Time Limit for Submitting Appeals**

Members have **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeal process will be lost.

### **9.2.3 The Review Process**

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. ODS' response time to an appeal is based on the nature of the claim as described below.

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

### **9.2.4 First Level Appeals**

Before filing an appeal, it may be possible to resolve a dispute with a phone call to ODS Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, ODS Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. ODS will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not previously involved in the original determination. The investigation will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, ODS will send a written notice of the decision to the member, including the basis for the decision. If applicable, the notice will include information on the right to a second level appeal.

### **9.2.5 Second Level Appeal**

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. A second level appeal must be submitted in writing within 60 days of the date of ODS' action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will follow the same timelines outlined in section 9.2.4. ODS will notify the member in writing of the decision, including the basis for the decision.

## 9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which healthcare expenses may be the responsibility of someone other than the Plan.

### 9.3.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 10.

### 9.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which benefits or healthcare costs were paid by the Plan. For example, a member who is injured may be able to recover the benefits or healthcare costs from a person 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, a member 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. If the Plan makes an advance payment of benefits, as described below, it is entitled to be reimbursed for any benefits it paid that are associated with any illness or injury that are or may be recoverable from a third party or other source. Amounts received by the Plan through these recoveries help reduce the cost of premiums and providing benefits.

Payment of benefits where a third party may be legally liable is excluded under the terms of the Plan. Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member's expenses based on the understanding and agreement that the member is required to honor the Plan's subrogation rights (section 9.3.2.2) and, if requested, to reimburse the Plan in full from any recovery the member may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that the Plan has the remedies and rights described in section 9.3.2. The Plan may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of reimbursement or subrogation as discussed in this section. ODS has the sole discretion to interpret and construe these reimbursement and subrogation provisions.

#### 9.3.2.1 Definitions:

For purposes of section 9.3.2, the following definitions apply:

**Benefits** means any amount paid by the Plan, or submitted to ODS for payment to or on behalf of a member. Bills, statements or invoices submitted to ODS by a provider of services, supplies or facilities to or on behalf of a member are considered requests for payment of benefits by the member.

**Recovery Funds** means any amount recovered from a third party.

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

**Third Party Claim** means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a member, regardless of how the claims, damages or recovery funds are characterized. (For example, a member who has received payment of dental/medical expenses from the Plan may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover benefits as described in section 9.3.2.)

#### **9.3.2.2 Subrogation**

Upon payment by the Plan, the Plan shall be subrogated to all of the member's rights of recovery. The member shall do whatever is necessary to secure such rights and do nothing to prejudice them. The Plan may pursue the third party in its own name or in the name of the member. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

#### **9.3.2.3 Right of Recovery**

In addition to its subrogation rights, the Plan may, at its sole discretion and option, ask that a member, and his or her attorney, if any, protect its reimbursement rights. The following rules apply to this right of recovery:

- a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.
- b. The Plan is entitled to receive the amount of benefits it has paid for that illness or injury out of any settlement or judgment that 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 member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.
- c. If the Plan asks the member and his or her attorney to protect its reimbursement rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.
- d. ODS may ask the member to sign an agreement to abide by the terms of this section. The Plan will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.
- e. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan out of any recovery made by the member from the third party, including, without limitation, any and all amounts from the first dollars paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.
- f. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

#### **9.3.2.4 Motor Vehicle Accidents**

Any expense for injury or illness that results from a motor vehicle accident and is payable under a motor vehicle insurance policy is not a covered benefit and will not be paid by the Plan.

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with ODS and motor vehicle insurance has not yet paid, then the Plan may advance benefits, subject to sections 9.3.2.2 and 9.3.2.3. In addition, in third party claims involving the use or operation of a motor vehicle, the Plan, at its sole discretion and option, is 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, or under applicable state law.

#### **9.3.2.5 Additional Third Party Liability Provisions**

In connection with the Plan's rights as discussed in the above sections, members shall do one or more of the following and agree that the Plan may do one or more of the following at its discretion:

- a. If a member seeks payment by the Plan of any benefits for which there may be a third party claim, the member shall notify ODS of the potential third party claim. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to ODS by the member's provider.
- b. Upon request from ODS, the member shall provide all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. The member and his or her representatives shall have the obligation to notify ODS in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.
- c. In order to receive an advance payment of benefits pursuant to section 9.3.2, the Plan requires any member seeking payment of benefits by the Plan, and if the member is a minor or legally incapable of contracting, then the member's parent or guardian, to fill out, sign and return to ODS a Third Party Reimbursement Questionnaire and Agreement, which includes a questionnaire about the accident and the potential third party claim. If the member has retained an attorney, then the attorney must also sign the agreement.
- d. The member shall cooperate with the Plan to protect its recovery rights, and in addition, but not by way of limitation, shall:
  - i. Sign and deliver any documents the Plan reasonably requires to protect its rights;
  - ii. Provide any information to ODS relevant to the application of the provisions of section 9.3.2, including dental/medical information (doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
  - iii. Take such actions as ODS may reasonably request to assist the Plan in enforcing its third party recovery rights.
- e. By accepting payment of benefits by the Plan, the member agrees that the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.
- f. The member agrees that ODS may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 9.3.2.

- g. Even without the member's written authorization, ODS may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 9.3.2.
- h. This section applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered.
- i. If the member continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.
- j. If the member or the member's representatives fail to do any of the foregoing acts at ODS' request, then the Plan has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the member 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, the Plan may notify dental/medical providers seeking authorization or prior authorization of payment of benefits that all payments have been suspended and may not be paid.
- k. Coordination of benefits (where the member has dental/medical coverage under more than one plan or health insurance policy) is not considered a third party claim.
- l. If any term, provision, agreement or condition of section 9.3.2 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.

## SECTION 10. COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has dental coverage under more than one plan.

### 10.1 DEFINITIONS

For purposes of Section 10, 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 covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

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

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

**Complying plan** is a plan that 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.

An **allowable expense** means a dental expense, including deductibles and copayments or coinsurance, that is covered at least in part by any plan covering the member. 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 member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

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

- a. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second opinions or prior authorization of services, or because the member has a lower benefit due to not using an in-network provider;
- b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
- d. If a member is covered by one plan that calculates its benefits 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 group dental benefit plan 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 group health plan providing dental benefits is separate from this Plan. A group health plan 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 calendar year excluding any temporary visitation.

## 10.2 HOW COB WORKS

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

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

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

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

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

### 10.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

- a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan which covers the member as a dependent.
- b. **Dependent Child/Parents Married, Registered Domestic Partners, or Living Together.** If the member is a dependent child whose parents are married, registered domestic partners, or are living together whether or not they have ever been married or registered domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)
- c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered domestic partners, then the following rules apply:
  - i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
  - ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
  - iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows:
    - A. The plan covering the custodial parent;
    - B. The plan covering the spouse or domestic partner of the custodial parent;
    - C. The plan covering the non-custodial parent; and then
    - D. The plan covering the spouse or domestic partner of the non-custodial parent.
- d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.

- e. **Active/Retired or Laid Off Employee.** The plan that covers a member 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 the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
- f. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, subscriber, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
- g. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
- h. **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.

#### **10.4 EFFECT ON THE BENEFITS OF THIS PLAN**

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

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

#### **10.5 ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION**

In order to receive benefits, the member must give ODS any information needed to pay benefits. ODS may release to or collect from any person or organization any needed information about the member.

#### **10.6 CORRECTION OF PAYMENTS**

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

## **10.7 RIGHT OF RECOVERY**

If the Plan pays more for a covered expense than is required by the Plan, the excess payment may be recovered from:

- a. The subscriber;
- b. Any person to whom the payment was made; or
- c. Any insurance company, service plan or any other organization that should have made payment.

## **SECTION 11. MISCELLANEOUS PROVISIONS**

### **11.1 REQUEST FOR INFORMATION**

When necessary to process claims, ODS may require a member to submit information concerning benefits to which he or she is entitled. ODS may also require a member to authorize any provider to give ODS information about a condition for which a member claims benefits.

### **11.2 CONFIDENTIALITY OF MEMBER INFORMATION**

Keeping a member's protected health information confidential is very important to the Group. Protected health information includes enrollment, claims, and medical and dental information. Such information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. ODS does not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses such information. ODS, as the third party administrator, is required to adhere to these same practices. Members can contact the Group regarding additional questions about the privacy of their information beyond that provided in the Notice of Privacy Practices.

### **11.3 TRANSFER OF BENEFITS**

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on ODS nor the Plan.

### **11.4 RECOVERY OF BENEFITS PAID BY MISTAKE**

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

### **11.5 CONTRACT PROVISIONS**

The agreement between the Group and ODS and handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the agreement plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

### **11.6 WARRANTIES**

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage

or reduce benefits unless contained in a written form and signed by the Group or the member, a copy of which has been given to the Group or member or the member's beneficiary.

#### **11.7 LIMITATION OF LIABILITY**

ODS shall incur no liability whatsoever to any member concerning the selection of dentists to render services. 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 the agreement between ODS and the Group shall be construed as obligating ODS to render dental services.

#### **11.8 PROVIDER REIMBURSEMENTS**

Dental care providers contracting with ODS to provide services to members agree to look only to ODS for payment of the part of the expense that is covered by the Plan and may not bill the member in the event the Plan fails to pay the provider for whatever reason. The provider may bill the member for applicable copayments or coinsurance and deductibles or non-covered expenses except as may be restricted in the provider contract.

#### **11.9 INDEPENDENT CONTRACTOR DISCLAIMER**

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 members may be deemed or construed to exist between ODS and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and ODS does not control the detail, manner or methods by which a participating dentist provides care.

#### **11.10 NO WAIVER**

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

#### **11.11 GROUP IS THE AGENT**

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

#### **11.12 GOVERNING LAW**

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

### **11.13 WHERE ANY LEGAL ACTION MUST BE FILED**

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

### **11.14 TIME LIMITS FOR FILING A LAWSUIT**

Any legal action arising out of, or related to, the Plan and filed against ODS or the Plan by a member or any third party must be filed in court within 3 years of the time the claim arose. All internal levels of appeal under the Plan must be exhausted before filing a claim in court.

## SECTION 12. CONTINUATION OF DENTAL COVERAGE

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

### 12.1 INDIVIDUAL DENTAL EXCHANGE PROGRAM

There is an individual dental plan available to members who have been covered under an employer-sponsored dental plan for 12 continuous months prior to their termination date and loss of coverage. A member 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 provided under the Group's dental plan. Members may enroll in this individual plan regardless of any other continuation coverage that may be available through the Group.

### 12.2 COBRA CONTINUATION COVERAGE

#### 12.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar. The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

- a. The Plan will offer no greater COBRA rights than the COBRA statute requires;
- b. The Plan will not provide COBRA coverage for those members who do not comply with the requirements outlined below.

For purposes of section 12.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

#### 12.2.2 Qualifying Events

**Subscriber.** A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment), a reduction in hours, or, for a retired subscriber, the Group files for reorganization under Chapter 11 of the bankruptcy code.

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

- a. Death of the subscriber;
- b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group;
- c. Divorce or legal separation from the subscriber;
- d. The subscriber becomes entitled to Medicare; or
- e. The retired subscriber's former employer (i.e. the Group) files for Chapter 11 reorganization.

(Also, if a subscriber 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 COBRA 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.)

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

- a. Death of the subscriber;
- b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group;
- c. Parents' divorce or legal separation;
- d. The subscriber becomes entitled to Medicare;
- e. The child ceases to be a "child " under the Plan; or
- f. The retired subscriber's former employer (i.e. the Group) files for Chapter 11 reorganization.

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

### 12.2.3 Other Coverage

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

### 12.2.4 Notice and Election Requirements

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

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

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

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

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

#### **12.2.5 COBRA Premiums**

Those eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage except for members who qualify for premium reduction under any applicable federal law. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. The Plan will not send a bill for any payments due. The member is responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

#### **12.2.6 Length of Continuation Coverage**

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

**18-Month Continuation Period.** In the case of a loss of coverage due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

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

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

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

#### **12.2.7 Extending the Length of COBRA Coverage**

If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure of the member 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 members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber'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 61<sup>st</sup> day after the subscriber'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 member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

A member must provide the COBRA 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 COBRA Administrator during the 60-day notice period and within 18 months after the subscriber'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 determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

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

This extension due to a second qualifying event is available only if the COBRA Administrator is notified 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 COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

#### **12.2.8 Newborn or Adopted Child**

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

### **12.2.9 Special Enrollment and Open Enrollment**

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add newborns, new spouses, or 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 members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

### **12.2.10 When Continuation Coverage Ends**

COBRA coverage will automatically terminate before the end of the maximum period if:

- a. any required premiums are not paid in full on time;
- b. a member becomes covered under another group dental plan (but only after any exclusions of that other plan for a preexisting condition have been exhausted or satisfied);
- c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits);
- d. the Group ceases to provide any group dental plan for its employees; or
- e. during a disability extension period (see section 12.2.7)), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will terminate).

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

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

## **12.3 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber 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 the subscriber pays 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 a subscriber does not elect continuation coverage under USERRA 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:

- a. On the first full business day following completion of his or her military service for a leave of 30 days or less;
- b. Within 14 days of completing military service for a leave of 31 to 180 days; or
- c. 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 the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period and the pre-existing condition limitation, if any, will be credited as if the subscriber had been continuously covered under the 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. Complete information regarding rights under USERRA is available from the Group).

#### **12.4 FAMILY AND MEDICAL LEAVE**

If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

- a. Affected members will remain eligible for coverage during a family and medical leave.
- b. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.
- c. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.

#### **12.5 LEAVE OF ABSENCE**

If granted a leave of absence by the Group, a subscriber may continue coverage for up to 3 months. Premiums must be paid to the **Group** in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Group at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the Group. A leave can be granted for any reason acceptable to the Group.

#### **12.6 STRIKE OR LOCKOUT**

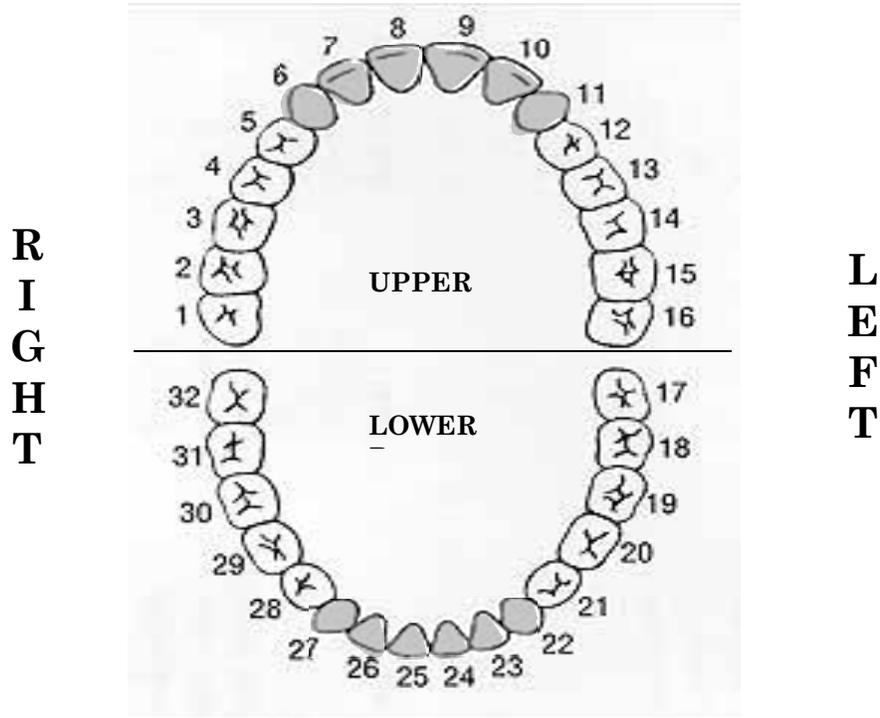
If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union or trust must continue to pay the Group the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

- a. Fewer than 75% of those normally enrolled choose to continue their coverage;
- b. A subscriber accepts full-time employment with another employer; or
- c. A subscriber otherwise loses eligibility under the Plan.

**SECTION 13. EXHIBITS**

**13.1 TOOTH CHART – THE PERMANENT ARCH**



Anterior teeth are shaded gray.

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

### 13.2 EXAMPLE OF HOW THE PLAN PAYS

The payments on specific claims will be based on the individual agreement between ODS and the dentist. Members seeing a participating Delta Dental Premier dentist may have a lower member responsibility, as some disallowed charges must be written off by the dentist. 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	Copay	Paid	Mbr. Resp.		
7/01/12	D2150 Amalgam Filling	30	\$120.00	\$20.00*	\$0.00	\$20.00	\$100.00	\$20.00	\$80.00	\$20.00		
7/01/12	D9215 Local Anesthesia	--	\$50.00	\$50.00**	\$0.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00		
<b>Totals:</b>			---	---	\$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	Copay	Paid	Mbr. Resp.		
7/01/12	D2150 Amalgam Filling	30	\$120.00	\$20.00*	\$0.00	\$0.00	\$100.00	\$20.00	\$80.00	\$40.00		
7/01/12	D9215 Local Anesthesia	--	\$50.00	\$50.00**	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00		
<b>Totals:</b>			---	---	\$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 Expens*

The amount a member would save, in this example, by seeing a Participating Delta Dental Premier Dentist is \$70.00



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

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