GROUP DENTAL PLAN

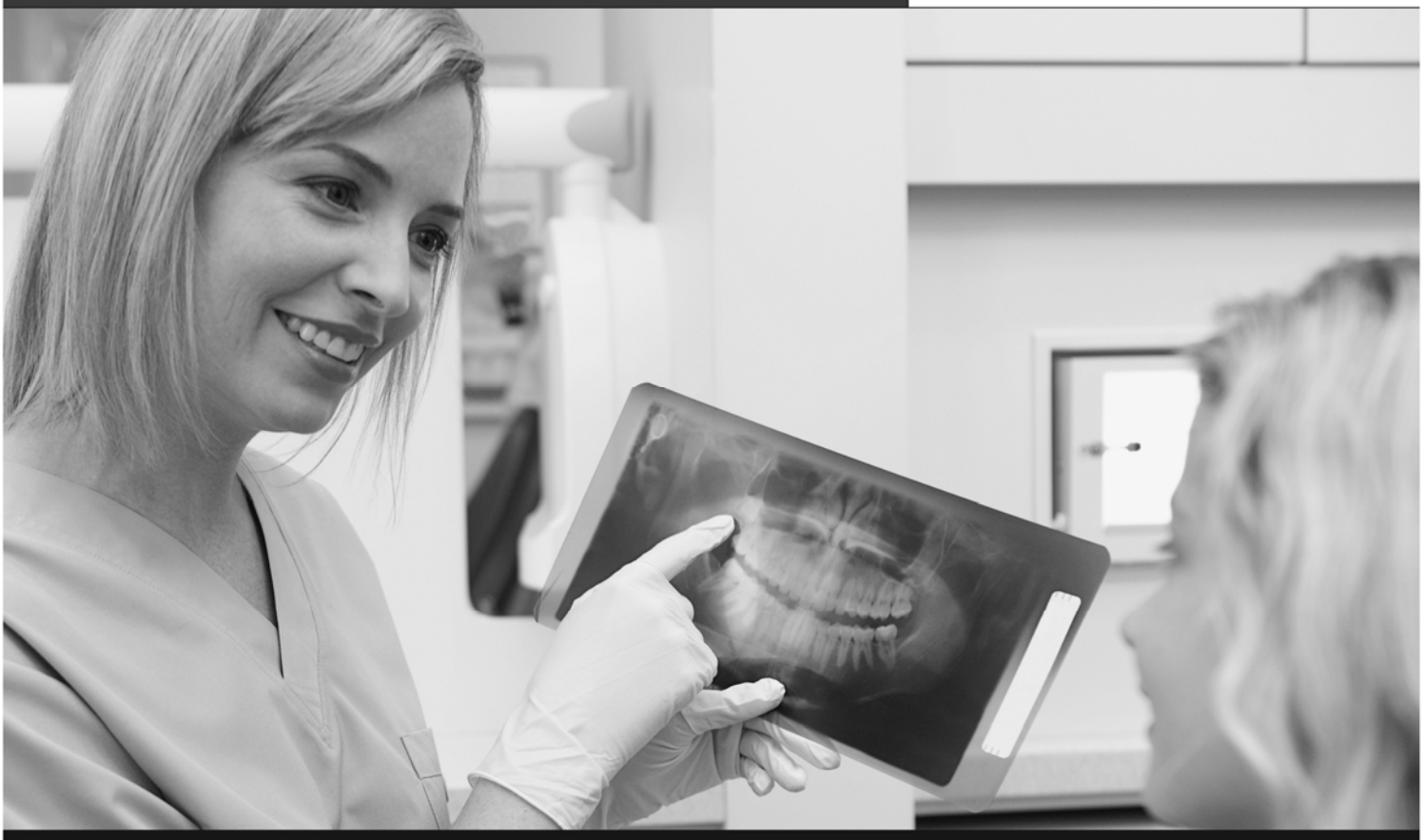
Lane Community College

Willamette Dental Plan

Effective Date: July 1, 2010

Group No. 10008142

www.odscompanies.com



Member handbooks and more are available at www.odscompanies.com

Insurance products provided by Oregon Dental Service

TABLE OF CONTENTS

SECTION 1. WELCOME

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

Members may direct questions to one of the numbers listed below or visit ODS' member self-help website, myODS, at www.odscompanies.com. myODS is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

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

Making Appointments or Selecting a Dentist

Portland	503-952-2100
Toll Free	800-461-8944

Patient Relations Department

Portland	503-952-2000
Toll Free	800-460-7644

Eligibility Inquiries

Portland	503-265-2965
Toll Free	888-217-2365
TDD/TTY	800-433-6313
	(for the hearing and speech impaired)
En Español	503-265-2963
Llamado Gratis	877-299-9063

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.

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

SECTION 2. GENERAL PLAN INFORMATION

2.1 **Plan Name:**
Lane Community College

2.2 **Plan Sponsor:**
Lane Community College

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

2.4 **Plan Year:** July 1st through June 30th**.**

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

2.6 **Funding Medium and Type of Plan Administration**: This Plan is fully insured. Benefits are provided under a group insurance policy entered into between Lane Community College and Oregon Dental Service. Willamette Dental Group will manage members' dental services and will process provider reimbursements and out-of-area emergency reimbursements. There is no need to send claims to Lane Community College or Oregon Dental Service.

The Plan is funded by the Group and/or subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion a subscriber pays toward the total contribution is determined by the Group, or Collective Bargaining Unit.

2.7 **Provider of Benefits**: Benefits are provided in accordance with a policy of insurance between Oregon Dental Service and Lane Community College.

2.8 **Named Fiduciary**: Lane Community College.

SECTION 3. USING THE PLAN

ODS' dental plans are easy to use. All of the paperwork takes place at a dentist's office, and members do not submit claims for reimbursement (except for dental emergencies). Benefits are provided for services rendered by network dentists selected from the network named in the following paragraph. Services must be performed by a network dentist unless members are referred to an outside dentist or specialist by a network dentist. The amount members pay for a covered service is listed in Section 16.

A member may choose any general dentist from the Willamette Dental Group Directory, which is available by visiting the Willamette Dental Group website or by calling the designated phone number listed in section 3.1 for assistance. A list of dental offices is found in Section 4.

Members should remember to make an appointment in advance with a network dentist before accessing dental care. If necessary, a network dentist will refer a member to an outside dentist or specialist. **Dental services that are not performed by a network dentist will not be covered by the Plan.**

At an initial appointment, members should tell the dental provider that they have dental benefits through ODS. Members will need to provide their subscriber identification number and ODS Group number to the dental office. These numbers are located on the I.D. card. Members are responsible for the member copayments at the time of dental service.

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

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

3.1 MEMBER RESOURCES

ODS Website (access **myODS** by clicking "a Member" and logging in)
www.odscompanies.com

Willamette Dental Group Website
www.willamettedental.com

Making Appointments
Portland 503-952-2100; Toll-free 800-461-8944;

Selecting a Dentist
Portland 503-952-2100; Toll-free 800-461-8944;

Eligibility Inquiries
Portland 503-265-2965; Toll-free 888-217-2365; TDD/TTY 800-433-6313; En Español 503-265-2963; Llamado gratis 877-299-9063

Appeals
Portland 503-952-2000; Toll-free 800-460-7644;

Patient Relations Department
Portland 503-952-2000; Toll-free 800-460-7644;

ODS' Dental Customer Service Department
Portland 503-265-2965; Toll-free 888-217-2365; TDD/TTY 800-433-6313; En Español 503-265-2963; Llamado gratis 877-299-9063

SECTION 4. LIST OF DENTAL OFFICES

Oregon Office Locations

Albany
2225 Pacific Boulevard. SE, Suite 201
Albany, OR 97321

Beaverton
14425 SW Allen Boulevard
Beaverton, OR 97005

Bend
Apple Tree Office Park, Building D
62968 O.B. Riley Road,
Bend, OR 97701

Corvallis
2420 NW Professional Drive, Suite 150
Corvallis, OR 97330

Eastport
4104 SE 82nd Avenue, Suite 450
Portland, OR 97266

Eugene
2703 Delta Oaks Drive
Eugene, OR 97408

Grants Pass
2166 NW Vine Street, Suite H
Grants Pass, OR 97526

Gresham
1107 NE Burnside Street
Gresham, OR 97030

Hillsboro
5935 SE Alexander Street
Hillsboro, OR 97123

Jefferson
1933 SW Jefferson Street
Portland, OR 97201

Lincoln City
1105 SE Jetty, Suite B
Lincoln City, OR 97367

Medford
773 Golf View Drive
Medford, OR 97504

Milwaukie
6902 SE Lake Road, Suite 200
Milwaukie, OR 97267

North Bend
2085 Inland Drive, Suite A
North Bend, OR 97459

Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97470

Salem – Lancaster
3490 Lancaster Drive NE
Salem, OR 97305

Salem – Liberty
4755 Liberty Road S
Salem, OR 97302

Springfield
2510 Game Farm Road
Springfield, OR 97477

Stark Street
13255 SE Stark Street
Portland, OR 97233

Tigard - Scholls
11415 SW Scholls Ferry Road
Beaverton, OR 97008

Tillamook
800 Main Avenue, Suite B
Tillamook, OR 97141

Tualatin
17130 SW Upper Boones Ferry Road
Durham, OR 97224

Weidler Street
220 NE Weidler Street
Portland, OR 97232

Washington Office Locations

Bellevue
Park 120 Office Complex
626 120th Avenue NE, Suite B210
Bellevue, WA 98005

Bellingham
Pacific Meridian Plaza
4164 Meridian Street
Bellingham, WA 98226

Everett
4310 Colby Avenue, Suite 300
Everett, WA 98203

Federal Way
181 S. 333rd Street, Suite C-100
Federal Way, WA 98003

Kennewick
Westhaven Professional Park
602 N. Colorado
Kennewick, WA 99336

Kent
24722 104th Avenue SE
Kent, WA 98031

Lakewood
9307 Bridgeport Way SW
Tacoma, WA 98499

Longview
1461 Broadway Street, Suite A
Longview, WA 98632

Lynnwood
Scriber Lake Office Center
6101 200th Street SW, Suite 201
Lynnwood, WA 98036

Olympia
Columbia Commons
3773-C Martin Way, Suite 105
Olympia, WA 98506

Pullman
Wheatland Shopping Center
1646 S. Grand Avenue
Pullman, WA 99163

Puyallup
702 South Hill Park Drive, Suite 201
Puyallup, WA 98373

Renton
1000 Oakesdale Avenue SW
Renton, WA 98055

Richland
104 Columbia Point Drive
Richland, WA 99352

Seattle – Dexter
133 Dexter Avenue N
Seattle, WA 98109

Seattle - Northgate
2111 N. Northgate Way, Suite 100
Seattle, WA 98133

Silverdale
3505 NW Anderson Hill Road
Silverdale, WA 98383

Spokane - Northpointe
9717 N. Nevada
Spokane, WA 99218

Spokane – South Hill
Fidelity Associates Building
501 S. Bernard, Suite 203
Spokane, WA 99204

Tumwater
6120 Capital Boulevard S
Tumwater, WA 98501

Vancouver - East
1201 SE Tech Center Drive, Suite 150
Vancouver, WA 98683

Vancouver - Hazel Dell
910 NE 82nd Street
Vancouver, WA 98665

Vancouver – Mill Plain
9609 Mill Plain Boulevard
Vancouver, WA 98664

Wenatchee
Mission Plaza Professional Center
317 N. Mission Street, Suite 200
Wenatchee, WA 98801

West Tacoma
Sixth Avenue Plaza Shopping Center
5401 Sixth Avenue
Tacoma, WA 98406

Yakima
1200 Chesterley Drive, Suite 230
Yakima, WA 98908

Idaho Office Locations

Boise
8950 W. Emerald Street, Suite 108
Boise, ID 83704

Coeur d'Alene
943 W. Ironwood Drive
Coeur d'Alene, ID 83814

Idaho Falls
3411 Merlin Drive
Idaho Falls, ID 83404

Meridian
Meridian Midvalley Professional Building
2365 Gala Street, Suite 1
Meridian, ID 83642

Nampa
222 W. Iowa Avenue, Suite 200
Nampa, ID 83686

Pocatello
1525 Baldy Avenue
Pocatello, ID 83201

Twin Falls
1411 Falls Avenue East
Twin Falls, ID 83301

Nevada Office Locations

Reno
3715 Lakeside Drive, Unit B
Reno, NV 89509

SECTION 5. DEFINITIONS

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

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan, 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 dentally necessary or appropriate.

Affidavit of Domestic Partnership means a signed document that attests the subscriber and one other eligible individual meet the criteria in the definition of unregistered domestic partner.

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

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.

Copay and Copayment means the fixed dollar amount listed in the member copayment schedule (see Section 16) to be paid by a member. Other than service charges, this is the only amount members must pay a network dentist for a covered service.

Dental Emergency means the sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring necessary care to control pain, swelling or bleeding in or around the teeth and gums. Such emergency care must be provided within 48 hours following the onset of the emergency and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or prosthetic benefits.

Dentally Necessary means services and supplies that, as determined by the network:

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.

Note:
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 doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

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.

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner.

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

Eligible Employee means any employee who meets the conditions of eligibility outlined in the Plan.

Enrollment Date means the date a subscriber's or dependent's coverage becomes effective under the terms of the Plan.

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 plan is a group health plan.

Investigational Service or Supply means a service or supply (including, but not limited to, equipment, drugs, devices, and other items) that is determined by the network to meet any one of the following:

a. Any service or supply classified by the network as experimental or investigational. Experimental and investigational shall mean services or supplies which are under continued scientific testing and research because they have not yet been proven to show a demonstrable benefit for a particular illness, disease or condition, or to be safe and efficacious.
b. Any service or supply that is on an investigational protocol, unless approved in writing in advance by the network.

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.

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

Network is the exclusive provider group that provides dental care to members.

Network Provider means a licensed dentist, certified denturist or registered hygienist who is employed by or is under contract with Willamette Dental Group or any of its affiliates to provide dental services.

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

Outside Dentist or Specialist means a licensed dentist who is not employed by or under contract with the network.

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).

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

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

The **Policy** is the agreement between the Group and ODS for insuring the dental benefit plan sponsored by the Group. This handbook is part of the policy.

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

Prophylaxis is cleaning and polishing of all teeth.

Reasonable Cash Value means the total fee for each service or supply that the network files with ODS.

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

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

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

Service Charge means a charge for a late cancellation of an appointment, for failing to keep or cancel an appointment, a delinquent account charge, and/or non-covered benefit fees.

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

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

a. Both are at least 18 years of age;
b. Are responsible for each other's welfare and are each other's sole domestic partners;
c. Are not married to anyone and have not had a spouse, a registered domestic partner, or another unregistered domestic partner within the prior 6 months. If previously married, the 6-month period starts on the final date of divorce;
d. Share a close personal relationship and are not related by blood closer than would bar marriage in the state of Oregon;
e. Have jointly shared the same regular and permanent residence for at least 6 months; and
f. 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.

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

Willamette Dental Dentist means a licensed dentist who is employed by or is under contract with Willamette Dental Group or any of its affiliates to provide dental services.

SECTION 6. BENEFITS AND LIMITATIONS

The Plan covers services when performed by a network provider (including licensed dentist, certified denturist or registered hygienist). Details on specific services covered are available in Section 16. Some procedures require a copayment amount, and members must pay this amount directly to the network dentist. If a member obtains dental services from an outside dentist, no benefits are payable and he or she will be responsible for the expenses incurred. (see sections 6.5 and 6.7 for exceptions.)

Before visiting a network provider, members should call the network and make an appointment. If members need to change a scheduled appointment, they should call in advance for cancellation and re-schedule for another day. There is a missed appointment fee if the appointment is canceled with less than 24 hours notice.

6.1 MEMBER COPAYMENT SCHEDULE

Details on covered services and copayments can be found in Section 16.

6.2 BENEFITS AND LIMITATIONS

Teeth Cleaning
Teeth cleaning frequency is determined at a member's first visit with a network dentist, who will make this determination based on what is dentally necessary. For example, members with gum disease may be scheduled for a cleaning every 3 months; however, members with healthy teeth and gums may only need a teeth cleaning once every 12 months. Frequency of other services is also determined by the Willamette Dental dentist.

6.3 EXTENSION OF BENEFITS

Dental benefits will be extended to cover the following services and supplies if coverage ends for any reason other than nonpayment of premium or amendment or termination of the policy.

a. Crowns and Bridges
When the final impressions are taken prior to termination and the crown or bridge is seated within 60 days after termination, adjustments will be covered up to 6 months after seating.

b. Removable Prosthetic Devices
When final impressions are taken prior to termination and the prosthesis is delivered within 60 days after termination, adjustments will be covered up to 6 months after seating. Laboratory relines will not be covered after termination.

c. Immediate Dentures
When final impressions are taken prior to termination and the dentures are delivered within 60 days after termination. However, if coverage for a member terminates prior to the actual extraction of teeth, the extractions will not be covered.

d. Root Canal Therapy and Root Canal Retreatment

When the root canal is started prior to termination and treatment is completed within 60 days after termination. A pulpotomy is considered definitive treatment and is not considered a root canal start. If the root canal fails after 60 days from the date of treatment and coverage has terminated, retreatment will not be covered. Restorative work is a separate procedure and is not covered after termination.

e. Extractions

Post-operative visit for extractions performed prior to termination will be covered for 60 days from the date of the extraction. Extractions are considered a separate procedure from prosthetic procedures. If a member has teeth extracted in preparation for a prosthetic device, but coverage terminates prior to the final impressions, the prosthetic device will not be covered.

6.4 HOSPITAL AND OTHER FACILITY CARE

Services may be provided in a hospital or other facility only when the following requirements are met:

a. A hospital setting must be medically necessary; and
b. The services must be authorized, in writing, in advance by the network.

Hospital facility charges are not a covered benefit.

6.5 REFERRED DENTAL CARE

If a network dentist refers a member to an outside specialist to obtain services that are covered under the Plan, the member is only responsible to pay the member copayments as shown in Section 16 and any applicable service charges.

However, the Plan does not cover treatment that is not authorized by a Willamette Dental dentist. Members are responsible for any additional charges by the outside dental specialist for procedures other than those specifically authorized by a Willamette Dental dentist.

6.6 EMERGENCIES

If there is an emergency, members should call and schedule an emergency appointment. Members are only responsible for the standard emergency office visit copayment as shown in Section 16 if emergency services are received within network office hours. For after-hours emergencies, members are subject to a separate after-hour emergency care copayment in addition to the standard emergency office visit copayment.

Network office hours are 7:00 a.m. to 8:00 p.m., Monday through Thursday, 7:00 a.m. to 6:00 p.m. Friday and 7:00 a.m. to 4:00 p.m. Saturday, (excluding all nationally recognized holidays). After-hours are all other hours and days in a calendar week.

6.7 OUT-OF-AREA EMERGENCIES

Members who are not able to get to a network provider while traveling at least 50 miles from a network office may go to any licensed dentist to obtain emergency treatment (relief from pain, bleeding, or swelling). The maximum amount of reimbursement is $100 less any applicable copayments and service charges. In no event will the differential between cost-sharing amounts for a member exceed $50 for dental emergency services provided by an outside dentist and a Willamette Dental dentist. Claims by an outside dentist must be paid in full by the member and then be sent to the network for reimbursement (see section 11.1).

For after-hours emergencies, members are also subject to a separate after-hour emergency care copayment.

SECTION 7. ORTHODONTIC BENEFIT

Orthodontic services are a benefit for members.

7.1 ORTHODONTIC BENEFITS

Orthodontic treatment started prior to enrolling for coverage under the plan will be pro-rated according to the extent of orthodontic services provided by Willamette Dental Group to complete the treatment plan. No benefits will be paid for services provided before coverage begins under this plan.

Orthodontic services as described below will be provided by a Willamette Dental Dentist or a Specialist when a treatment plan is prepared by a Willamette Dental Dentist prior to rendering services. The treatment plan is based on an examination that must take place while you or your dependent are covered under the contract, and the examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care.

Services connected with orthodontic treatment will be provided subject to the co-payments listed below and the applicable co-payments listed in Appendix A to this plan. There are no limitations to the length of orthodontic treatment provided you or your dependent remain covered under the contract. Once active treatment ends, there will be no additional orthodontic service co-payments for 3 years provided that the post-treatment plan is followed and appointments are kept.

Appliances (including, but not limited to, headgear or retainers) for you or your dependents will not be covered under the contract unless some or all of the prior orthodontic treatment was provided under the contract. No benefits will be provided for appliances being replaced. If coverage under the contract ends before orthodontic treatment is completed, there may be additional charges for orthodontic services provided after the termination or change in your or your dependent's dental coverage. Continuing orthodontic treatment will be pro-rated based on fee-for-service rates. If orthodontic coverage terminates before the end of the prescribed treatment period, benefits will continue through the end of the month in which the orthodontic coverage was terminated.

7.2 PRE-ORTHODONTIC SERVICE COPAYMENT

You or your dependent will be responsible for paying the co-payment amounts listed below for pre-orthodontic services provided:

- Initial orthodontic exam $25
- Study models and x-rays $125
- Case presentation No Co-pay

The pre-orthodontic co-payments will be subtracted from Comprehensive orthodontia treatment Co-pay if member proceeds with treatment.

7.3 ORTHODONTIC SERVICE COPAYMENT

You or your dependent will be responsible for paying the co-payment amount listed below for orthodontic services provided:

- Comprehensive orthodontic services – all levels: $1,500
- Limited orthodontic services: Co-payment will be pro-rated based on the treatment rendered, provided that such co-payment shall not exceed the co-payment for comprehensive orthodontic services shown above.

7.4 ORTHODONTIC SERVICES PROVIDED

The following are the orthodontic services provided under this plan:

ADA Code	Procedure
D8020	Limited orthodontic treatment – Transitional (Mixed dentition)
D8030	Limited orthodontic treatment – Adolescent (Permanent dentition – growing)
D8040	Limited orthodontic treatment – Adult (Permanent dentition – not growing)
D8060	Interceptive orthodontic treatment – Transitional
D8070	Comprehensive orthodontic treatment – Transitional (Mixed dentition)
D8080	Comprehensive orthodontic treatment – Adolescent (Permanent dentition – growing)
D8090	Comprehensive orthodontic treatment – Adult (Permanent dentition – not growing)
D8691	Repair of Orthodontic Appliance

Please see the Exclusions section of the handbook for additional exclusions.

SECTION 8. 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 dental provider.

Accidental Injury
The Plan does not cover services that are provided for accidental injury to natural teeth more than 12 months after the date of the accident.

Anesthesia or Sedation
General anesthesia, including moderate or deep sedation, unless it is determined at the sole discretion of the Willamette Dental Dentist to be medically necessary. Under no circumstances will general anesthesia, including moderate or deep sedation, be provided for comfort or due to psychological disorders.

Athletic Activities
Any injuries sustained while practicing for or competing in a professional or semiprofessional athletic contest are excluded. Semiprofessional athletics means an athletic activity for gain or pay that requires an unusually high level of skill and substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.

Benefits Not Stated
Services or supplies that are not listed as covered under the Plan are excluded.

Bleaching of a Tooth

Cast Dowel Posts

Claims Not Submitted Timely
Claims for out-of-area emergencies submitted more than 6 months after the date of service are excluded.

Congenital or Developmental Malformations
The Plan does not cover services or supplies provided to correct congenital or developmental malformations including, but not limited to, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypolasis, ectodental displasia, and fluorosis (discoloration of teeth).

Cosmetic
Cosmetic dentistry or surgery (not including orthodontia) is excluded.

Facility Fees
The Plan does not cover hospital or other facility care for dental procedures, including physician services for hospital treatment. (See section 6.4 for exceptions)

Federal, State or Governmental Program
The Plan does not cover services to the extent that coverage is available under any federal, state or governmental program if application is duly made, except where required by law such as cases of emergency or for coverage provided by Medicaid.

Full-Mouth Reconstruction

Habit-Breaking or Stress-Breaking Appliances

Implants
Dental implants or implant supported prosthetics are excluded.

Intentionally Self-Inflicted Injuries
Intentionally self-inflicted injuries are excluded. The fact that a member may be under the influence of any chemical substance shall not be considered as a limitation on the ability to form the intent specified in this exclusion.

Investigational
Investigational services or supplies are excluded.

Materials Not Approved by the American Dental Association

Medications and Supplies
Prescription drugs, medications or supplies are excluded.

Occupational Injury or Disease
Occupational injury or disease (including any arising out of self-employment) is excluded.

OSHA Requirements
Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements are excluded.

Orthodontia
The Plan does not cover extraction of permanent teeth for tooth guidance procedures, procedures for tooth movement regardless of purpose, correction of malocclusion, preventive orthodontic procedures, or other orthodontic treatment, unless specifically provided in a rider under the Plan.

Orthognathic Surgery

Precision Attachments and Other Special Techniques
Personalized restoration, precision attachments, and special techniques are excluded.

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Splints, occlusal guards, nightguards, and other appliances used to increase vertical dimension and restore bite are excluded.

Repair and Replacement
Repair or replacement of lost, stolen or broken items is excluded.

Replacement Before Frequency Limit Is Met
Replacements of an existing denture, crown, or bridge less than 5 years after the date of the most recent placement are excluded.

Restorations Not Dentally Necessary
Replacement of sound restorations is excluded.

Restorations on Posterior Teeth
Veneers or composite surfaces on posterior teeth are excluded.

Services Not Provided by a Dental Provider
Charges by any person other than a licensed dentist, licensed denturist, or licensed hygienist are excluded.

Services Otherwise Available
The Plan does not cover charges that would not have been made or that members would have had no obligation to pay in the absence of coverage under the Plan.

Service Related Conditions
Any condition resulting from military service or declared or undeclared war is excluded.

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party. This 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 11.3).

TMJ
Services for temporomandibular joint disorders are excluded.

Treatment Before Coverage Begins
The Plan does not cover dental services started prior to the date the member became eligible for services under the Plan.

Treatment Not Dentally Necessary
The Plan does not cover:

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

Treatment Not Necessary for an Injury
The Plan does not cover services that are not necessary for treatment of a dental injury or disease or are not recommended and approved by the licensed dentist who is treating a member.

Treatment With Multiple Visits
The Plan does not cover endodontics, bridges, crowns or other services or prosthetic devices requiring multiple treatment dates or fittings if treatment was started or ordered prior to a member's effective date under the Plan or if the item was installed or delivered more than 60 days after the coverage has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within 60 days after termination.

Tumor Related Services
The Plan does not cover excision of a tumor, biopsy of soft or hard tissue, or removal of a cyst or exostosis.

SECTION 9. ELIGIBILITY

This section describes who is eligible to enroll in the Plan. The date a person becomes eligible may be different than the date coverage begins (see section 10.5).

9.1 SUBSCRIBERS

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

a. is a permanent documented 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 the minimum of hours required by the Collective Bargaining Agreement;
e. satisfies any eligibility waiting period; and
f. applies to and is accepted by ODS to be enrolled in the Plan.

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under the Family and Medical Leave Act of 1993, as amended. Members should check with the Group to find out whether they qualify for this provision.

9.2 DEPENDENTS

A subscriber's legal spouse or registered domestic partner is eligible for coverage. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. A subscriber's dependent children are eligible until their 25th birthday, if they are not married or registered under the Oregon Family Fairness Act, are dependent on you for full or partial support, or if a court or administrative order requires you to provide health coverage. (Information on the date coverage will end is available in section 10.6.6).

Please Note:
The Group offers same gender and opposite gender domestic partner coverage.

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. Children of a covered dependent child, until the dependent child is no longer eligible under the plan; 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 25 years old. 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 25th birthday. The subscriber must provide ODS with a written physician's statement that confirms that these conditions existed continuously prior to the child's 25th 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.

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

9.3 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 Plan Administrator determines that the applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Plan Administrator without charge.

9.4 NEW DEPENDENTS

If a subscriber marries, the spouse and his or her children are eligible to enroll as of the date of the marriage. A complete and signed application along with a valid marriage certificate must be submitted within 31 days of the date of the marriage (see section 10.5). All dependents must meet eligibility requirements.

If a subscriber registers a Declaration of Domestic Partnership under the Oregon Family Fairness Act while enrolled in the Plan, the registered domestic partner and his or her children are eligible for coverage. A complete and signed application along with a valid Certificate of Registered Domestic Partnership must be submitted within 31 days of the date the Declaration of Domestic Partnership is registered (see section 10.5). All dependents must meet eligibility requirements.

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 complete and signed application along with a copy of the Affidavit of Domestic Partnership must be submitted within 31 days of the date the Affidavit of Domestic Partnership is filed.

A member's newborn child will automatically be enrolled for 31 days after birth. When adding the child will cause a premium increase (e.g., from an employee and spouse tier to a family tier), a complete and signed application and payment must be submitted within those 31 days listing the new child as a dependent. If payment is required but not received, the child will not be covered.

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. When adding the child will cause a premium increase (e.g., from an employee and spouse tier to a family tier), a complete and signed application and payment must be submitted along with the placement or adoption paperwork within those 31 days listing the child as a dependent. If payment is required but not received, the child will not be covered.

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.

Note: 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.

9.5 RETIREMENT

9.5.1 Employee Eligibility

Those employees eligible for retirement under ORS 243.303 and the eligibility rules of the Oregon Public Employees Retirement System (PERS), will be allowed to continue the dental plan coverage after retirement as long as application for enrollment is made within 60 days of the effective date of retirement. Benefits and coverage will be the same as for active employees.

9.5.2 Dependent Eligibility

If a dependent is carried on a member's insurance immediately prior to the member's retirement, the dependent is allowed to continue on the member's insurance during retirement. If a dependent chooses not enroll at the time of the employee's retirement, the dependent's coverage will end and the dependent may not re-enroll at a later date. New dependent(s) acquired after an employee's retirement date are eligible to enroll on the plan as long as application for enrollment is made within 31 days of first becoming eligible for coverage. New dependent(s) who do not enroll upon initial eligibility will not be allowed to enroll at a future date.

9.5.3 When Retiree Eligibility Ends

Eligibility for a retiree will end on the last day of the month in which he or she:

- Dies;
- Reaches age 65;
- Voluntarily terminates enrollment for him or herself and all enrolled dependents;
- Or, just prior to the month in which the retiree becomes eligible for Medicare.

Eligibility for a spouse will end on the last day of the month in which:

- A decree of divorce is final (may then be eligible for COBRA continuation);
- He/she voluntarily terminates enrollment, either individually or through the retiree;

Eligibility for a dependent child will end on the last day of the month in which the child:

- Is no longer eligible according to the terms of the contract;
- Voluntarily terminates enrollment, either individually or through the retiree.

A retiree, his or her spouse, and/or dependent child(ren) who voluntarily terminate coverage may not re-enroll.

Refer to Continuation of Dental Coverage section of the Benefit Handbook for COBRA and portability information.

SECTION 10. ENROLLMENT

This section explains how to enroll in the Plan.

10.1 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's payroll or personnel office.

An employee who is also a dependent of another employee, still must be enrolled as an employee. No employee may be enrolled solely as a dependent of another employee.

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

10.2 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents due to marriage or domestic partnership by submitting a complete and signed application within 31 days of their eligibility. When a premium increase is required in order to cover newborn children or for an adopted child or a child placed for adoption, a complete and signed dependent application and payment must be submitted (along with the placement or adoption paperwork, if applicable) within 31 days of birth, adoption or placement for adoption.

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

10.3 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 in section 10.4.

10.4 SPECIAL ENROLLMENT RIGHTS

10.4.1 Loss of Other Coverage

If coverage is declined for an eligible employee or any dependent(s) when initially eligible because of other dental coverage, they 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 packet option, unless a 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.

10.4.2 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 10.4.1 and 10.4.2 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 coverage under the other plan or becomes eligible for a premium assistance subsidy;
c. To both the eligible employee and the dependent if neither is enrolled in the Plan, and either loses coverage under the other plan 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.

10.4.3 New Dependents

New dependents under the terms of the Plan may enroll outside of open enrollment periods if they request special enrollment within 31 days after the event that caused the subscriber to gain a new dependent (e.g., marriage, the registration of a Declaration of Domestic Partnership, the filing of an Affidavit of Domestic Partnership, birth, adoption, or placement for adoption). The eligible employee and spouse or domestic partner will also 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; however, other existing dependents will not.

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, a copy of Certificate of Registered Domestic Partnership, a copy of the filed Affidavit of Domestic Partnership, or adoption or placement for adoption paperwork must be submitted.

10.5 WHEN COVERAGE BEGINS

Coverage begins for you and any enrolled dependents on the first day of the month following your date of hire. When the new dependent results from marriage, coverage is effective on the day of marriage. When the new dependent results from domestic partnership, coverage is effective on the date the Declaration of Domestic Partnership is registered, or the Affidavit of Domestic Partnership is filed. Newborn children are eligible to begin coverage on the date of their birth, adopted children or children placed for adoption are eligible to begin coverage on the date of adoption or placement, court ordered coverage is effective on the date specified by the court order, or if you are enrolled under a Collective Bargaining Agreement which states otherwise. The necessary premiums must also be paid for coverage to become effective.

Coverage for late enrollees will begin on the date ODS specifies with the acceptance of the application. All other plan provisions will apply. Coverage under special enrollment will begin on the first day of the month following receipt of the special enrollment request.

10.6 WHEN COVERAGE ENDS

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

10.6.1 Termination of the Group Plan

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

ODS may terminate the group policy for fraud, material misrepresentation, or concealment by the Group, or for the Group's noncompliance with material policy provisions.

10.6.2 Termination by a Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving ODS written notice through 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.

10.6.3 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 14). The Group must notify ODS of any continuation of coverage, and appropriate premiums must be paid along with the Group's regular monthly payment.

10.6.4 Loss of Eligibility, Layoff, or Leave of Absence

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 14).

If a subscriber is laid-off by the Group and returns to active work within 18 months of being laid off, he or she and any previously enrolled dependents may re-enroll in the group plan on the date of rehire. Coverage will begin on the first day of the month following the date of rehire.

If a subscriber experiences a loss of eligibility due to a qualifying leave of absence, as defined by the specific working agreement, he or she and any previously enrolled dependents may re-enroll in the group plan upon the subscriber's return to work in a qualifying position. Coverage will begin the first day of the month in which the subscriber returns to work in the qualifying position, as defined by the specific working agreement (see Section 14.6 for coverage during a leave of absence).

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.

The Group must notify ODS that a subscriber has been rehired following a layoff or that a subscriber's hours have been increased, and the necessary premiums for coverage must be paid.

10.6.5 Termination by Willamette Dental Group

Coverage may terminate if the network has documented good cause for termination, such as an inability to establish or maintain a patient/provider relationship between a member and a Willamette Dental dentist at locations reasonably accessible to the member. Coverage will end on the last day of the month following a 30-day written notice from Willamette Dental Group. If a member's coverage is terminated, coverage for any dependents also ends at the same time.

10.6.6 Loss of Eligibility by Dependent

An enrolled child will lose eligibility when he or she marries, registers a Declaration of Domestic Partnership under the Oregon Family Fairness Act, reaches age 25, is no longer dependent on the subscriber, or when the subscriber is no longer legally required to provide coverage for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under the Plan (see Section 14).

Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under the Plan (see Section 14).

Coverage ends for a registered domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered, unless the former registered domestic partner continues coverage as provided under the Plan (see Section 14).

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.

10.6.7 Rescission by Insurer

ODS 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. As used herein, fraud, material misrepresentation, or concealment 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. ODS reserves the right to retain premium paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. Should ODS 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 our affiliates.

10.6.8 Other

Additional information is in Section 14.

SECTION 11. CLAIMS ADMINISTRATION AND PAYMENT

The following section explains how claims are administered.

11.1 SUBMISSION AND PAYMENT OF CLAIMS

When a member sees a Willamette Dental dentist, all of the paperwork takes place at the dentist's office, and there is no need to submit claims.

Claims by an outside dentist must be paid in full by the member and then be sent to the following address for reimbursement.

Willamette Dental Group
Attention: Administrative Application Specialist
6950 NE Campus Way
Hillsboro, OR, 97124

If a claim form is submitted, it must be completely filled out and signed by the member and the outside dentist. An itemized statement from the outside dentist must also be included. The network has the right to request additional information from the outside dentist needed to process the claim. No reimbursement will be provided unless the requested information is received. All claims must be submitted within 6 months of the date of service. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

11.2 APPEALS

This section explains how appeals are administered.

A member with questions or concerns regarding a decision, action, or statement by a Willamette Dental dentist should discuss with the Willamette Dental dentist at the time of the appointment. If the member remains dissatisfied after the discussion, he or she may submit a first level appeal to the network's Patient Relations Department.

11.2.1 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 initial appeal is not submitted within the timeframes outlined in this section, the member will lose the right to the appeal process.

11.2.2 The Appeal Process

The Plan has a 2-level appeal process. The first level of review is a first level appeal. The second level of review is a second level appeal.

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

a. The member does not reasonably cooperate; or
b. 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.

11.2.3 First Level Appeals

Members may request a review of an adverse benefit determination. It may be possible to resolve the situation with a phone call to Patient Relations Department. Otherwise, a First Level Appeal must be submitted in writing and sent to the following address: Willamette Dental Group, 6950 NE Campus Way, Hillsboro, OR, 97124. If necessary, the Patient Relations Department can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the appeal 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 request for benefits. The appeal will be reviewed by persons not previously involved in the benefit determination.

The investigation of an appeal of an adverse benefit determination will be completed within 30 days of receipt of the appeal.

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

11.2.4 Second Level Appeals

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 sent in writing within 60 days of the date of the action on the first level appeal.

The second level appeal will be reviewed by persons not previously involved in the review of the appeal or benefit determination. The member will have the option to submit written comments, documents, records and other information related to the case that was not previously submitted.

The member will be notified in writing of the decision within 30 days of receipt of the appeal, including the basis for the decision.

11.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

11.3.1 Coordination of Benefits (COB)

This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 12.

11.3.2 Third-Party Liability

A member may have a legal right to recover benefit or dental care costs from another person, organization or entity, or an insurer, as a result of an injury for which benefits were provided by a network provider. For example, a member who is injured may be able to recover the benefits or dental care 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 be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for dental care expenses connected with the injury. The network is entitled to be reimbursed for any benefits that it provides that are associated with any injury and are or may be recoverable from a third party or other source.

As a service, the network will provide benefits to a member based on the understanding and agreement that the member is required to honor the network's rights of subrogation as discussed below, and, if requested by the network, to reimburse it in full from any recovery the member may receive, no matter how the recovery is characterized.

Upon accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that the network shall have the remedies and rights as stated in this section. The network 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 network's right of reimbursement or subrogation as discussed in this section. The network has the sole discretion to interpret and construe these reimbursement and subrogation provisions.

11.3.2.1 Definitions

For purposes of section 11.3, the following definitions apply:

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 the characterization of the claims or damages of the member, and regardless of the characterization of the recovery funds. (For example, a member who has received benefits from the network 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 network is still entitled to recover the value of the benefits provided, as described in section 11.3.2).

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

Recovery Funds means any amount recovered from a third party.

11.3.2.2 Subrogation

Upon provision of services by the network, it shall be subrogated to all of the member's rights of recoveries therefore, and the member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this subsection, the network may pursue the third party in its own name, or in the name of the member. The network is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

11.3.2.3 Right of Recovery

In addition to its subrogation rights, the network may, at its sole discretion and option, ask that a member, and his or her attorney, if any, protect its reimbursement rights. If the network elects to proceed under this subsection, the following rules apply:

a. The member holds any rights of recovery against the third party in trust for the network, but only for the amount of benefits provided for that injury.

b. The network is entitled to receive the value of benefits it has provided for that 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 network is entitled to receive the value of benefits it has paid whether the dental care expenses are itemized or expressly excluded in the third party recovery.

c. If, and only if, the network asks the member, and his or her attorney, to protect its reimbursement rights under this subsection, then the member may subtract from the money to be paid back to the network, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

d. The network may ask the member to sign an agreement to abide by the terms of this subsection.

e. This right of recovery includes the full amount of the benefits provided 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 dental 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 network'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 provided by the network, the member shall seek recovery of such future expenses in any third party claim.

11.3.2.4 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 under the Plan.

The network may provide benefits, subject to the rights and remedies outlined in the subsections 11.3.2.2 and 11.3.2.3, and subject to the next paragraph.

In addition to the rights and remedies outlined in subsections 11.3.2.2 and 11.3.2.3, in third party claims involving the use or operation of a motor vehicle, the network, 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.

11.3.2.5 Additional Third Party Liability Provisions

In connection with the network's rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above subsections, members shall do one or more of the following and agree that the network may do one or more of the following, at its discretion:

a. If the member seeks benefits for which there may be a third party claim, the member shall notify the network of the potential third party claim.

b. Upon request from the network, 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 the network 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 for benefits provided by the network from the third party.

c. The member shall cooperate with the network to protect its recovery rights, and in addition, but not by way of limitation, shall:

   i. Sign and deliver such documents as the network reasonably requires to protect its rights;
   ii. Provide any information to the network relevant to the application of the provisions of this section, including dental information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
   iii. Take such actions as the network may reasonably request to assist it in enforcing its rights to be reimbursed from third party recoveries.

d. By accepting benefits from the network, the member agrees that it has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

e. The member agrees that the network may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 11.3.2.

f. Even without the member's written authorization, the network may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 11.3.2.

g. Section 11.3.2 applies to any member for whom benefits are provided whether or not the event giving rise to the member's injuries occurred before the member became covered under the Plan.

h. If the member continues to receive dental treatment for an injury after obtaining a settlement or recovery from a third party, the network will provide benefits for the continuing treatment of that 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.

i. If the member or the member's representatives fail to do any of the foregoing acts at the network's request, then the network has the right to suspend benefits for or on behalf of the member related to any injury or dental condition arising out of the event giving rise to, or the allegations in, the third party claim.

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

k. If any term, provision, agreement or condition of section 11.3.2 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 12. COORDINATION OF BENEFITS

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

12.1 DEFINITIONS

For purposes of Section 12, 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 trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; 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, coinsurance, and copayments, 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 part of this group policy that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing dental benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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. This Plan is a closed panel plan.

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.

12.2 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 the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

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

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

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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

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.

12.3 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 under the Oregon Family Fairness Act, or Living Together.** If the member is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the 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'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
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 under the Oregon Family Fairness Act, 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 has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the dependent 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.

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

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 'ii' or 'iii') above shall determine the order of benefits as if those persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

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

f. **COBRA or State Continuation Coverage.** If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, primary insured, or retiree (non-dependent) longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits

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.

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

12.4 EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If a member is enrolled in 2 or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

12.5 ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

12.6 FACILITY OF PAYMENT

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

12.7 RIGHT OF RECOVERY

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

SECTION 13. MISCELLANEOUS PROVISIONS

The following describes other procedures and policies in effect when processing claims.

13.1 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of a member's protected health information is of extreme importance to ODS. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. ODS uses such information 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 information about how ODS uses members' information. A copy of the notice is available on ODS' website by following the HIPAA link or by calling ODS at 503-243-4492.

13.2 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.

13.3 CONTRACT PROVISIONS

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

13.4 WARRANTIES

All statements made by the Group or a member, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting 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 to the member or the beneficiary of the member.

13.5 LIMITATION OF LIABILITY

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

13.6 PROVIDER REIMBURSEMENTS

Willamette Dental dentists agree that they will accept fees in the amount established by the network as full payment for their services, except for the member's copayment responsibility and charges for a late cancellation of an appointment, for failing to keep or cancel an appointment, a delinquent account charge, and/or non-covered benefit fees as provided for in the Plan. Willamette Dental dentists agree that their charges to members will not exceed the copayment amounts listed in Section 16.

13.7 INDEPENDENT CONTRACTOR DISCLAIMER

ODS and Willamette Dental dentists are independent contractors. ODS and Willamette Dental 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 Willamette Dental dentist's provision of dental care to ODS members may be deemed to exist or be construed to exist between ODS and Willamette Dental dentists. A Willamette Dental 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 Willamette Dental dentist provides care.

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

13.9 GROUP IS THE AGENT

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

13.10 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.

13.11 WHERE ANY LEGAL ACTION MUST BE FILED

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

13.12 TIME LIMITS FOR FILING A LAWSUIT

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

SECTION 14. CONTINUATION OF DENTAL COVERAGE

14.1 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 group dental plan. Members may enroll in this individual plan regardless of any other continuation coverage that may be available through the Group.

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

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

14.2.1 Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group dental insurance policies to offer enrolled spouses and registered domestic partners the opportunity to request a temporary extension of dental insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation").

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

a. ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
b. ODS will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice, election, or other requirements outlined in the following sections; and
c. The Group is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group to notify the eligible spouse or registered domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or registered domestic partner. The Group shall be responsible for such premiums.

14.2.2 Eligibility Requirements for 55+ Oregon Continuation Coverage

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

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

14.2.3 Notice And Election Requirements For 55+ Oregon Continuation Coverage

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

Election Notice. Within 44 days of the death of the subscriber, the Plan Administrator shall provide notice to the surviving, legally separated or divorced spouse, or the surviving, legally separated or former registered domestic partner, that coverage can be continued, along with an election form. If the Plan Administrator fails to notify the surviving, legally separated or divorced spouse, or the surviving, legally separated or former registered domestic partner, within the required 14 days, premiums shall be waived until the date notice is received.

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

14.2.4 Premiums For 55+ Oregon Continuation Coverage

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

14.2.5 When 55+ Oregon Continuation Coverage Ends

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

a. The failure to pay premiums when due, including any grace period allowed by the Plan;
b. The date that the Plan terminates, unless a different group policy is made available to the Group members;
c. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former registered domestic partner, becomes insured under any other group dental plan;
d. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former registered domestic partner, remarries or registers another domestic partnership and becomes covered under another group dental plan; or
e. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former registered domestic partner, becomes eligible for Medicare.

14.3 COBRA CONTINUATION COVERAGE

14.3.1 Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of section 14.3, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event and can include the subscriber and the subscriber's spouse and dependent children. The Plan Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration. Specific qualifying events are listed below.

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

a. ODS will offer no greater COBRA rights than the COBRA statute requires;
b. ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election or other requirements outlined below;
c. ODS will not provide COBRA coverage if the Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the Plan Administrator otherwise fails to comply with any of the requirements outlined below; and
d. ODS will not provide a disability extension if the Plan Administrator fails to notify ODS within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

14.3.2 Qualifying Events

a. **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, but is not limited to, 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.

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

   i. The death of the subscriber;
   ii. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group;
   iii. Divorce or legal separation from the subscriber;
   iv. The subscriber becomes entitled to Medicare; or
   v. 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 Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

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

   i. The death of the subscriber;
   ii. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group;
   iii. Parents' divorce or legal separation;
   iv. The subscriber becomes entitled to Medicare;
   v. The dependent ceases to be a "dependent child" under the Plan; or
   vi. The retired subscriber's former employer (i.e. the Group) files for Chapter 11 reorganization.

d. **Same Sex Domestic Partners.** A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

e. **Opposite Sex 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 a "Qualified Beneficiary" 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).

14.3.3 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.

14.3.4 Notice and Election Requirements

Qualifying Event Notice. The Plan provides that a 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 Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the member(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

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

Otherwise, members will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the 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 Plan 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.

14.3.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, under the law, 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 qualified beneficiary 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 Plan 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 premium. ODS will not send a bill for any payments due. The qualified beneficiary is responsible for paying the applicable premium, 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.

14.3.6 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 (other than for gross misconduct) 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 dependent 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 (other than for gross misconduct) 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 qualified beneficiaries (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.

14.3.7 Extending the Length of COBRA Coverage

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

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from 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 61st 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 qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Plan 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 qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours.

A qualified beneficiary must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the 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 premiums.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, he or she must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the 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 dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when 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 Plan 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 Plan Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or registered domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 14.2).

14.3.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered a qualified beneficiary. 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 Group within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the Group in a timely fashion, the child will not be eligible for continuation coverage.

14.3.9 Special Enrollment and Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated members who are not enrolled in COBRA. A qualified beneficiary 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.

14.3.10 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 qualified beneficiary becomes covered, after electing COBRA, under another group dental plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
c. a qualified beneficiary 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 qualified beneficiary 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 14.3.7), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

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

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

14.3.11 The American Recovery and Reinvestment Act of 2009 as amended

This Act provides for premium reductions and additional election opportunities for continuation coverage under COBRA. Eligible members pay 35% of their COBRA premiums. The premium reduction applies to periods of dental coverage beginning on or after February 17, 2009 and continues up to 15 months for those eligible for COBRA due to an involuntary termination of employment that occurred during the period beginning September 1, 2008 and ending May 31, 2010 (or later if this Act is amended subsequently). Questions about this Act and related notice requirements should be directed to the Plan Administrator.

14.4 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).

14.5 FAMILY AND MEDICAL LEAVE

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

a. Affected members will remain eligible for coverage during a FMLA leave.
b. A subscriber's rights under FMLA will be governed by that statute and its regulations.
c. If members elect not to remain enrolled during a FMLA 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 policy 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.

14.6 LEAVE OF ABSENCE

If granted a non-FMLA leave of absence by the Group, a subscriber may continue coverage for up to 12 months. Premiums must be paid through 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, including disability and maternity.

14.7 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 ODS 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 15. RESERVED FOR FUTURE USE

SECTION 16. SCHEDULE OF COVERED SERVICES AND COPAYMENTS

	ADA Code	Procedure	Co-payment
1.		**Office Visit Charge**	$ 10
2.		**Diagnostic and Preventative Services**	
	D0120	Periodic oral evaluation	No Co-pay
	D0140	Limited oral evaluation-emergency	No Co-pay
	D0145	Oral Evaluation – Patient Under 3 years	No Co-pay
	D0150	Comprehensive oral evaluation	No Co-pay
	D0160	Detailed & extensive oral evaluation	No Co-pay
	D0170	Re-evaluation - limited	No Co-pay
	D0180	Comprehensive periodontal evaluation	No Co-pay
	D0210	Complete series x-rays	No Co-pay
	D0220	Periapical-first film	No Co-pay
	D0230	Intraoral - each additional film	No Co-pay
	D0240	Intraoral - occlusal film	No Co-pay
	D0250	Extraoral - first film	No Co-pay
	D0260	Extraoral - each additional	No Co-pay
	D0270	Bitewings - single film	No Co-pay
	D0272	Bitewings - two films	No Co-pay
	D0273	Bitewings –three films	No Co-pay
	D0274	Bitewings-four films	No Co-pay
	D0277	Vertical bitewings	No Co-pay
	D0330	Panoramic x-rays	No Co-pay
	D1110	Teeth cleaning (prophylaxis) adult	No Co-pay
	D1120	Teeth cleaning (prophylaxis) child	No Co-pay
	D1203	Topical fluoride-child	No Co-pay
	D1204	Topical fluoride-adult	No Co-pay
	D1206	Topical fluoride-therapeutic application	No Co-pay
	D1310	Nutritional counseling	No Co-pay
	D1320	Tobacco counseling	No Co-pay
	D1330	Oral Hygiene Instruction	No Co-pay
	D0340	Cephalometric film	No Co-pay
	D0350	Oral / facial images	No Co-pay
	D1351	Sealant – per tooth	No Co-pay
	D0425	Caries susceptibility test	No Co-pay
	D0460	Pulp vitality test	No Co-pay
	D0470	Diagnostic casts	No Co-pay
3.		**Space Maintainers**	
	D1510	Space Maintainer – unilateral-fixed	No Co-pay
	D1515	Space Maintainer – bilateral-fixed	No Co-pay
	D1520	Space Maintainer – unilateral-removable	No Co-pay
	D1525	Space Maintainer – bilateral removable	No Co-pay
	D1550	Space Maintainer – recement	No Co-pay
	D1555	Removal of fixed space maintainer	No Co-pay
4.		**Restorative Dentistry**	

a. Amalgam Restorations –

D2140	Fillings – 1 surface	No Co-pay
D2150	Fillings – 2 surfaces	No Co-pay
D2160	Fillings – 3 surfaces	No Co-pay
D2161	Fillings – 4 or more surfaces	No Co-pay
D2951	Pin retention – per tooth, in addition to restoration	No Co-pay
D2940	Sedative filling – temporary	No Co-pay

b. Resin Restorations

D2330	Resin-1 surface (anterior only)	No Co-pay
D2331	Resin-2 surfaces (anterior only)	No Co-pay
D2332	Resin-3 surfaces (anterior only)	No Co-pay
D2335	Resin-4 surfaces (anterior only)	No Co-pay
D2390	Resin Based composite crown	No Co-pay
D2950	Core buildup, including any pins	No Co-pay
D2391	Resin-one surface posterior (primary only)	No Co-pay
D2392	Resin-two surfaces posterior (primary only)	No Co-pay
D2393	Resin-three surfaces posterior (primary only)	No Co-pay
D2394	Resin four or more surfaces posterior (primary only)	No Co-pay
	Posterior Composites on permanent teeth	Not covered

c. Inlay/Onlay (cast restorations)

D2510	Inlay-gold 1 surface	No Co-pay
D2520	Inlay-gold 2 surfaces	No Co-pay
D2530	Inlay-gold 3 or more surfaces	No Co-pay
D2542	Onlay-gold 2 surfaces	No Co-pay
D2543	Onlay-gold 3 surfaces	No Co-pay
D2544	Onlay-gold 4 or more surfaces	No Co-pay
D2610	Inlay-porcelain/ceramic 1 surface	No Co-pay
D2620	Inlay-porcelain/ceramic 2 surfaces	No Co-pay
D2630	Inlay-porcelain/ceramic 3 surfaces	No Co-pay
D2642	Onlay-porcelain/ceramic 2 surfaces	No Co-pay
D2643	Onlay-porcelain/ceramic 3 surfaces	No Co-pay
D2644	Onlay-porcelain 4 or more surfaces	No Co-pay
D2910	Recement inlay	No Co-pay

5. Crowns

D2710	Crown-resin laboratory	No Co-pay
D2740	Crown-porcelain/ceramic (anterior only)	No Co-pay
D2752	Crown-porcelain/noble	No Co-pay
D2782	¾ crown – noble	No Co-pay
D2792	Full cast crown – noble	No Co-pay
D2920	Recement crown	No Co-pay
D2970	Temporary crown for fractured tooth	No Co-pay
D2930	Stainless Steel crown-primary	No Co-pay
D2931	Stainless Steel crown-permanent	No Co-pay
D2932	Crown-prefabricated resin	No Co-pay
D2933	Crown-prefabricated stainless steel with resin window	No Co-pay
D2954	Prefabricated dowel post & core	No Co-pay

D2955	Post removal (no endodontic therapy)	No Co-pay
D2957	Each additional prefabricated post - same tooth	No Co-pay
D2980	Repair crown	No Co-pay

6. Endodontics

D3110	Pulp cap-direct excluding final restoration	No Co-pay
D3120	Pulp cap-indirect	No Co-pay
D3220	Pulpotomy – A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	No Co-pay
D3221	Gross pulpal debridement – primary & permanent teeth	No Co-pay
D3230	Pulpal therapy – primary anterior	No Co-pay
D3240	Pulpal therapy – primary posterior	No Co-pay
D3310	Root canal therapy – anterior	No Co-pay
D3320	Root canal therapy – bicuspid	No Co-pay
D3330	Root canal therapy – molar	No Co-pay
D3331	Treatment of root canal obstruction – non-surgical access	No Co-pay
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	No Co-pay
D3333	Internal repair of perforation defects	No Co-pay
D3346	Retreatment – anterior	No Co-pay
D3347	Retreatment – bicuspid	No Co-pay
D3348	Retreatment – molar	No Co-pay
D3351	Apexification – initial visit	No Co-pay
D3352	Apexification – interim visit	No Co-pay
D3353	Apexification – final visit	No Co-pay
D3410	Apicoectomy – anterior	No Co-pay
D3421	Apicoectomy – bicuspid 1st root	No Co-pay
D3425	Apicoectomy – molar 1st root	No Co-pay
D3426	Apicoectomy – each additional root	No Co-pay
D3430	Retrograde filling – per root	No Co-pay
D3450	Root amputation per tooth	No Co-pay
D3920	Hemisection	No Co-pay
D3950	Canal prep-preform dowel/post	No Co-pay

Note: When initial root canal therapy was performed by a Willamette Dental dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable Co-pays will apply.

7. Periodontics

D4210	Gingivectomy or gingivoplasty 4 or more teeth	No Co-pay
D4211	Gingivectomy – 1 to 3 teeth	No Co-pay
D4240	Gingival flap 4 or more teeth	No Co-pay
D4241	gingival flap 1 to 3 teeth	No Co-pay
D4249	Crown lengthening hard tissue	No Co-pay
D4260	Osseous surgery – 4 or more teeth	No Co-pay
D4261	Osseous surgery 1 to 3 teeth	No Co-pay
D4263	Bone replacement graft – 1st site in quadrant	No Co-pay

D4264	Bone graft – each additional site in quadrant	No Co-pay
D4270	Pedicle soft tissue graft procedure	No Co-pay
D4271	Free soft tissue graft procedure	No Co-pay
D4273	Subepithelial connective graft	No Co-pay
D4274	Distal wedge procedure	No Co-pay
D4341	Periodontic scale & root plane – 4 or more teeth	No Co-pay
D4342	Periodontic scale & root plane – 1 to 3 teeth	No Co-pay
D4355	Preliminary full-mouth debridement	No Co-pay
D4381	Antimicrobial irrigation	No Co-pay
D4910	Periodontic maintenance following therapy	No Co-pay

8. Prosthodontics - Removable

D5110	Complete (upper denture)	No Co-pay
D5120	Complete (lower denture)	No Co-pay
D5130	Immediate (upper denture)	No Co-pay
D5140	Immediate (lower denture)	No Co-pay
D5211	Upper partial resin base	No Co-pay
D5212	Lower partial resin base	No Co-pay
D5213	Upper partial cast metal frame	No Co-pay
D5214	Lower partial cast metal frame	No Co-pay
D5281	Partial-removable unilateral	No Co-pay
D5225	Upper partial flexible base	No Co-pay
D5226	Lower partial flexible base	No Co-pay
D5410	Adjustment – complete denture, upper	No Co-pay
D5411	Adjustment – complete denture, lower	No Co-pay
D5421	Adjustment – partial denture, upper	No Co-pay
D5422	Adjustment – partial denture, lower	No Co-pay
D5510	Repair broken denture no teeth damaged	No Co-pay
D5520	Repair denture replace missing or broken teeth (each tooth)	No Co-pay
D5610	Repair resin base	No Co-pay
D5620	Repair partial cast framework	No Co-pay
D5630	Repair or replace partial clasp	No Co-pay
D5640	Replace teeth – partial per tooth	No Co-pay
D5650	Add tooth to existing partial	No Co-pay
D5660	Add clasp to existing partial	No Co-pay
D5710	Rebase complete upper denture	No Co-pay
D5711	Rebase complete lower denture	No Co-pay
D5720	Rebase upper partial	No Co-pay
D5721	Rebase lower partial	No Co-pay
D5730	Reline complete upper denture (chairside)	No Co-pay
D5731	Reline complete lower denture (chairside)	No Co-pay
D5740	Reline upper partial (chairside)	No Co-pay
D5741	Reline lower partial (chairside)	No Co-pay
D5750	Reline upper denture – lab	No Co-pay
D5751	Reline lower denture – lab	No Co-pay
D5760	Reline upper partial – lab	No Co-pay
D5761	Reline lower partial – lab	No Co-pay
D5810	Interim denture – upper	No Co-pay
D5811	Interim denture – lower	No Co-pay
D5820	Interim partial – upper	No Co-pay
D5821	Interim partial – lower	No Co-pay

D5850	Tissue conditioning – upper	No Co-pay
D5851	Tissue conditioning – lower	No Co-pay
D5860	Overdenture – complete	No Co-pay
D5861	Overdenture – partial	No Co-pay
D5986	Fluoride gel custom trays	No Co-pay

9. Prosthodontics - Fixed

D6210	Pontic, cast (per tooth) traditional fixed partial dentures only (bridges)	No Co-pay
D6240	Pontic (per tooth); porcelain/metal traditional fixed partial dentures only (bridges)	No Co-pay
D6241	Pontic (per tooth) maryland bridge	No Co-pay
D6545	Cast metal retainer	No Co-pay
D6720	Crown-resin/metal abutment	No Co-pay
D6750	Crown-porcelain metal abutment	No Co-pay
D6780	Crown ¾ cast metal abutment	No Co-pay
D6790	Crown – full gold abutment	No Co-pay
D6930	Recement bridge	No Co-pay
D6972	Prefabricated post/core in addition to bridge	No Co-pay
D6973	Core build-up with or without pins	No Co-pay
D6975	Coping – metal	No Co-pay
D6980	Bridge repair	No Co-pay

10. Oral Surgery

D7111	Extraction coronal remnants primary tooth	No Co-pay
D7140	Extraction erupted tooth	No Co-pay
D7210	Surgical extraction – erupted	No Co-pay
D7220	Removal of impacted tooth – soft tissue	No Co-pay
D7230	Removal of impacted tooth – partial bony	No Co-pay
D7240	Removal of impacted tooth – complete bony	No Co-pay
D7241	Removal of impacted tooth – complete bony with complications	No Co-pay
D7250	Surgical removal residual root	No Co-pay
D7260	Oroantral fistula closure	No Co-pay
D7270	Tooth re-implantation	No Co-pay
D7280	Surgical access unerupted tooth	No Co-pay
D7283	Ortho bracket to aid eruption if plan covers orthodontia	No Co-pay
D7291	Transseptal fiberotomy	No Co-pay
D7310	Alveoloplasty w/extractions-4 or more teeth, per quadrant	No Co-pay
D7311	Alveoloplasty w/extractions- 1-3 teeth, per quadrant	No Co-Pay
D7320	Alveoloplasty w/o extractions-4 or more teeth, per quadrant	No Co-pay
D7321	Alveoloplasty w/o extractions- 1-3 teeth, per quadrant	No Co-pay
D7471	Removal of lateral exostosis	No Co-pay
D7550	Remove non-vital bone segment	No Co-pay
D7960	Frenectomy	No Co-pay
D7510	I & D intraoral soft tissue	No Co-pay
D7520	I & D extraoral soft tissue	No Co-pay
D7530	Remove foreign body – soft tissue	No Co-pay
D7540	Remove foreign body – hard tissue	No Co-pay

D7670	Stabilization splint-alveolus	No Co-pay
D7910	Suture small wound up to 5 cm	No Co-pay
D7911	Complicated suture up to 5 cm	No Co-pay
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	No Co-pay
D7970	Excision hyperplastic tissue	No Co-pay
D7971	Excision of pericoronal flap	No Co-pay

11. Anesthesia

D9215	Local anesthesia (Novocain)	No Co-pay
D9230	Nitrous Oxide (per visit)	$ 15
D9220	General Anesthesia – 1st 30 minutes*	Not Covered
D9221	General Anesthesia – Each Additional 15 minutes*	Not Covered

12. Miscellaneous

D9310	Consultation – per session	No Co-pay
D9911	Application of desensitizing medicaments	No Co-pay
D9430	Observation visit	No Co-pay
D9440	Emergency treatment – after office hours	$ 20
D9951	Occlusal adjustment - simple	No Co-pay
D9952	Occlusal adjustment - complete	No Co-pay
D9110	Palliative (emergency) minor	No Co-pay
D9420	Hospital call (dental treatment provided in a hospital setting in addition to any other applicable service co-pays; facility fees not covered) (service co-pays still apply)	$ 125
	Out-of-area emergency reimbursement	Up to $ 100
	Cancellation of appointment without 24 hour notice	$20

13. Orthodontia

Comprehensive orthodontia treatment	$1,500
Initial orthodontic exam*	$25
Study models & x-rays*	$125
Case presentation	No Co-pay

*Subtracted from Comprehensive orthodontia treatment Co-Pay if enrollee proceeds with treatment.

14. Exclusions See Exclusions section of the Contract.

Insurance products provided by Oregon Dental Service

Making Appointment or Selecting a Dentist
Portland 503-952-2100
Toll-Free 800-461-8944

Patient Relations Department
Portland 503-952-2000
Toll-Free 800-460-7644

Eligibility Inquiries
Portland 503-265-2965
Toll-Free 888-217-2365
TDD/TTY 800-433-6313
En Español 503-265-2963
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