



2025

Oregon Group Dental Plan

Special Districts Insurance Services (SDIS)
Constant 1500 with Pediatric Plan
Delta Dental Premier® Plan Preventive First
July 1, 2025
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SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON

The Plan is self-funded. This means money that pays your claims comes from the Group. We are pleased your Group has chosen Delta Dental to provide claims and administrative services. Where this book talks about Delta Dental paying claims, it means we are issuing benefits that the Group is providing (paying).

This handbook will give you important information about the Plan's benefits, limitations and procedures. It does not waive any of the conditions of the Plan as set out in the Plan Document. The Plan is self-funded and the Group has contracted with Delta Dental Plan of Oregon to provide claims and other administrative services.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.deltadentalor.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

This handbook may be changed or replaced at any time without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Delta Dental determines there is a legitimate business purpose for doing so.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to your Member Dashboard)

www.DeltaDentalOR.com

Includes many helpful features, such as Find Care (use it to find a participating dentist)

Dental Customer Service Department

Toll-free 844-235-8018

En español 877-299-9063

Appeals Department

P.O. Box 40384

Portland, OR 97240

Fax 503-412-4003

Telecommunications Relay Service for the hearing impaired

711

Delta Dental

P.O. Box 40384

Portland, Oregon 97240

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers. Show your card each time you receive services, so your dentist will know you are a Delta Dental member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

2.3 NETWORK

Network Information (section 3.1) explains how networks work. This is the network for your Plan.

Dental network

Delta Dental Premier®

2.4 OTHER RESOURCES

You can find other general information about the Plan in Section 11.

SECTION 3. USING THE PLAN

If you have questions about the Plan, contact Customer Service. This handbook describes the benefits of the Plan. Review this handbook carefully. It is your responsibility to be aware of the Plan's limitations and exclusions.

At a first appointment, tell the dentist that you have dental benefits administered by Delta Dental. You will need to provide your ID number and Delta Dental group number to the dentist. These numbers are located on your ID card.

3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. If you choose a participating Delta Dental Premier® dentist from the Delta Dental Premier Dental Directory (use Find Care on your Member Dashboard), all of the paperwork takes place between the dentist's office and us. Thousands of all licensed dentists in Oregon are participating Delta Dental Premier dentists. If you are outside Oregon, Delta Dental Plans Association provides offices and/or contacts in every state. We can process dental claims for services you get any place in the world.

If you need dental care, you may go to any dental office. There are differences in how the Plan pays for participating Delta Dental Premier dentists and non-participating dentists or dental care providers. You may choose to use any dentist, but we cannot guarantee that any particular dentist will be available.

3.1.1 Non-Participating Dentists

Payment to a non-participating dentist or dental care provider is at the applicable coinsurance and is limited to the PPO fee schedule. The allowable fee in states other than Oregon is the Delta Affiliate's non-participating dentist allowance for that state. You may have to pay the difference between the maximum allowed amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, we provide a predetermination service. Your dentist may send us a predetermination request to get an estimate of what the Plan would pay. We will process the request according to the Plan's current benefits and return it to your dentist. You and your dentist should review the information before beginning treatment.

SECTION 4. BENEFITS AND LIMITATIONS

The Plan covers the services listed when performed by a dentist or dental care provider (licensed dentist or licensed hygienist). They are only covered when they are determined to be necessary and customary by the standards of generally accepted dental practice to prevent or treat oral disease or accidental injury. Our dental consultants and dental director determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance (MPA). Benefits will never be paid for services that are beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered by your medical plan are not covered on this Plan except when they are related to an accident.

Covered dental services are grouped in 3 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services and are noted below. See Section 6 for exclusions.

Covered services, when generally accepted dental practices and standards determine they can be safely and effectively provided using teledentistry (audio, video or both), are covered when you get them from a provider using such telephone or internet conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information.

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

Deductible: \$25

Per member (not to exceed \$75 per family) per year, or portion thereof
Deductible applies to covered Class II and Class III services

Out-of-Pocket maximum for members under age 19:

\$425 for one member, \$850 for 2 or more members per year.
All covered services except orthodontia accrue to the out-of-pocket maximum.

Annual maximum plan payment limit for members age 19 and over:

\$1,500 per member per year, or portion thereof
All covered services except class I and orthodontia apply to the annual maximum plan payment limit.
You will have to pay any amount over the annual maximum plan payment limit.

4.1 CLASS I

COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE

4.1.1 Diagnostic

a. Diagnostic Services:

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

b. Diagnostic Limitations:

- i. Periodic (routine) or comprehensive exams (including problem focused comprehensive exams) or consultations are covered twice per year
- ii. Limited exams or re-evaluations are covered twice per year
- iii. Complete series x-rays or a panoramic film is covered once in any 5-year period
- iv. Supplementary bitewing x-rays are covered once per year
- v. Separate charges to review a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
- vi. Only these x-rays are covered: complete series or panoramic, periapical, occlusal and bitewing

4.1.2 Preventive

a. Preventive Services:

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

b. Preventive Limitations:

- i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year.† Additional periodontal maintenance is covered if you have periodontal disease, up to a total of 4 cleanings per year.
- ii. Adult prophylaxis is only covered if you are age 12 and over. Child prophylaxis is covered if you are under age 12.
- iii. Topical application of fluoride is covered twice per year if you are under age 19. If you are age 19 and over, topical application of fluoride is covered twice per year if you have a recent history of periodontal surgery or a high risk of decay because of medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene is not a medical disease).
- iv. Interim caries arresting medicament application is covered twice per tooth per year.
- v. Sealants are only covered on the unrestored occlusal surfaces of permanent molars. Benefits are limited to one sealant per tooth during any 5-year period
- vi. Space maintainers are covered for one space per quadrant if you are under age 14. Space maintainers for primary anterior teeth or missing permanent teeth or if you are age 14 and over are not covered.

†Additional cleaning benefit is available if you have diabetes or are in the third trimester of pregnancy. To be eligible for this additional benefit, you must enroll in the Oral Health, Total Health program (see Section 5).

4.2 CLASS II

COVERED SERVICES PAID AT 80% OF THE MAXIMUM PLAN ALLOWANCE

4.2.1 Restorative

a. Restorative Services:

- i. Amalgam fillings and composite fillings to treat decay
- ii. Stainless steel crowns

b. Restorative Limitations:

- i. Restorations are not covered within 2 months of interim caries arresting medicament application.
- ii. Inlays are considered an optional service. We will pay an alternate benefit of a composite filling.
- iii. Crown buildups are included in the crown restoration cost. A buildup is covered only if necessary for tooth retention.
- iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains.
- v. Replacement of a stainless steel crown by the same dentist within 2 years of placement is not covered. The replacement is included in the charge for the original crown.
- vi. See section 4.3.1 for additional limitations when teeth are restored with crowns or cast restorations.

4.2.2 Oral Surgery

a. Oral Surgery Services:

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

b. Oral Surgery Limitations:

- i. A separate, additional charge for alveoloplasty done along with removal of teeth is not covered.
- ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
- iii. A separate charge for post-operative care done within 30 days after an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
- iv. Brush biopsy is covered twice per year. Benefits are limited to the sample collection. Pathology (lab) services are not covered.

4.2.3 Endodontic

a. Endodontic Services:

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

b. Endodontic Limitations:

- i. A separate charge for cultures is not covered.
- ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
- iii. A separate charge for pulp capping is not covered. Pulp capping is considered to be included in the fee for the final restoration.
- iv. Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not covered. The retreatment is included in the charge for the original care.
- v. A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.

4.2.4 Periodontic

a. Periodontic Services:

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

b. Periodontic Limitations:

- i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
- ii. Periodontal maintenance is covered under Class I, Preventive.
- iii. A separate charge for post-operative care done within 3 months after periodontal surgery is not covered.
- iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
- v. Bone replacement grafts are covered once per quadrant in a 3-year period.
- vi. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
- vii. Full mouth debridement is limited to once in a 2-year period. If you are age 19 or older, it is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2-years.

4.2.5 Anesthesia

a. General anesthesia or IV sedation

Covered only:

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

4.3 CLASS III

COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

4.3.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

- i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See 4.2.1 for limitations on buildups.
- ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. We will pay for a gold restoration, and you will have to pay the difference.
- iii. If your tooth can be restored by an amalgam or composite filling, but you or your dentist choose another type of restoration, the covered expense is limited to a composite. Crowns are only covered if the tooth cannot be restored by a routine filling.
- iv. Restorations are not covered within 2 months of interim caries arresting medicament application.
- v. A separate, additional charge to repair a restoration done within 2 years of the original restoration is not covered.
- vi. Re-cement or re-bond of a crown, inlay, or veneer by the same dentist is limited to once per lifetime.

4.3.2 Prosthodontic

a. Prosthodontic Services:

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

b. Prosthodontic Limitations:

- i. A bridge or a full or partial denture is covered once in a 7-year period and only if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last 7 years.
- ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount is limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- iii. Partial dentures: A temporary (interim) partial denture is only covered to replace missing anterior permanent teeth for members age 16 or under when placed within 2 months of the extraction of an anterior tooth. If a specialized or precision device is used, covered expense is limited to the cost of a standard cast partial denture. Cast restorations for partial denture retainer teeth are not covered unless the tooth requires a cast restoration because it is decayed or broken.
- iv. Denture adjustments, repairs and relines: A separate, additional charge for denture adjustments, repairs and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
- v. Tissue conditioning is covered no more than twice per denture in a 3-year period.
- vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and

debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years. The Plan will also cover:

- A. The final crown and implant abutment over a single implant. These benefits are limited to once per tooth or tooth space over the lifetime of the implant
- B. An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device
- C. The final implant-supported bridge retainer and implant abutment, or pontic. This benefit is limited to once per tooth or tooth space over the lifetime of the implant
- D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth
- E. This benefit or alternate benefits is not provided if the tooth, implant or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years
- vii. Re-cementing or re-bonding an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.
- viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to a corresponding metallic prosthetic. You will have to pay the difference.
- ix. Fixed bridges or removable cast partial dentures are not covered if you are under age 16.

4.3.3 Other

a. Other Services:

- i. Athletic mouthguard
- ii. Nightguard (occlusal guard)
- iii. Orthodontia, including placement of a device to facilitate eruption of an impacted tooth, for correcting malocclusioned teeth when necessity is established through an in-person clinical examination of the member. You should check with your participating district to find out whether you qualify for this coverage.

b. Other Limitations:

- i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period if you are age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are not covered.
- ii. A nightguard (occlusal guard) is covered once every 2-year period at 100% up to \$200 maximum with no deductible. You will have to pay for any amount above the \$200 maximum. Repair or relin and adjustment of an occlusal guard is covered once every 12-month period following 6 months of initial placement. Over-the-counter nightguards are not covered.
- iii. Lifetime maximum of \$1,500 per member for orthodontic services. This maximum is not included in the annual maximum plan payment limit. Any deductible is waived.
- iv. Pre-orthodontic treatment exam is part of the comprehensive orthodontic treatment plan.
- v. Self-administered orthodontics are not covered.

- vi. Payment for orthodontia will end when treatment stops for any reason before completion, or when your eligibility ends or the Plan ends. If treatment began before you were eligible under the Plan, we will base the Plan's obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.
- vii. A separate charge for a retainer, or the repair or replacement of an appliance furnished under the Plan is not covered.

4.4 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, we will pay the applicable percentage of the maximum plan allowance for the least costly treatment. You will have to pay the rest of the dentist's fee.

4.5 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For members with intellectual or developmental disabilities, we cover some extra services to help them get the dental care they need:

- a. Visits before the first treatment, to help members learn what to expect
- b. Up to 2 extra cleanings per year
- c. Silver diamine fluoride to stop the progression of cavities for members who cannot tolerate the use of certain dental instruments
- d. Sedation
- e. Dental case management for members with special healthcare needs (such as sensory issues, behavioral challenges, severe anxiety) that make dental care difficult

Call Customer Service to find out how to get these extra benefits.

SECTION 5. ORAL HEALTH, TOTAL HEALTH BENEFITS

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

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

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

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

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

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

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. If you are pregnant, you are eligible for a cleaning in the third trimester of pregnancy regardless of when you had a previous cleaning.

5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on your Member Dashboard. If you have diabetes, you must include proof of diagnosis.

SECTION 6. EXCLUSIONS

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

Analgesics

Substances used for pain relief

Anesthesia or Sedation

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

Behavior Management

Additional services, time or assistance to control the actions of a member (except as stated in section 4.5)

Benefits Not Stated

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

Claims Not Submitted Timely

Claims submitted more than 12 months after the date of service

Congenital or Developmental Malformations

Includes treating cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth)

Coping

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

Cosmetic Services

Any service or supply with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in dental function. Examples include, tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

Experimental or Investigational Procedures

Including expenses related to or needed because of such procedures

Facility Fees

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

Gnathologic Recordings

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

Hypnosis**Illegal Acts**

Services and supplies to treat an injury or condition caused by or arising directly from your illegal act

Inmates

Services and supplies you get while in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions or Training

Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction, except as described in section 4.5 for IDD

Localized Delivery of Antimicrobial Agents

Time released antibiotics to remove bacteria from below the gumline

Maxillofacial Prosthetics

Except surgical stents as stated in section 4.3.2

Medications**Missed Appointment Charges****Never Events**

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

Orthodontia

Except for members with orthodontia coverage

Over-the-Counter

Including over the counter occlusal guards and athletic mouthguards

Periodontal Charting

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

Precision Attachments

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

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth

Including services only to prevent wear or protect worn or cracked teeth, except occlusal or athletic mouthguards as provided in section 4.3.3. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

Self-Treatment

Services you provide to yourself

Service Related Conditions

Treatment of any condition caused by or arising out of your service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by your military or veterans coverage.

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

Someone else should have been responsible for the cost of these services or supplies. Examples include when payment or compensation should be provided by:

- a. Workers' compensation or employer's liability laws
- b. Any city, county, state or federal law, except Medicaid
- c. Any municipality, county or other political subdivision or community agency without cost to you, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
- d. Separate contracts that are used to provide coordinated coverage and are considered parts of the same plan

Taxes**Teledentistry Fees**

A separate charge for teledentistry is not covered. Teledentistry is covered in the normal charge for the service.

Third Party Liability Claims

Services and supplies to treat illness or injury that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 7.3.2)

TMJ

Treatment of any disturbance of the temporomandibular joint (TMJ)

Translation and Sign Language Services

Included in the fees for overall patient management and are not covered separately

Treatment After Coverage Ends

Except for cast restorations and prosthodontic services that were ordered and fitted while you were still eligible, and then only if they are cemented within 31 days after your eligibility ends. This exception does not apply if the Group or participating district transfers its plan to another administrator.

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

Including services and supplies that are:

- a. Not dentally necessary to treat or prevent a dental injury or disease otherwise covered under the Plan
- b. Inappropriate with regard to standards of good dental practice
- c. Have a poor prognosis

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

Treatment of Closed Fractures

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 SUBMISSION AND PAYMENT OF CLAIMS

What to know about sending us a claim:

- a. We must receive your claim no more than 12 months after the date of service
- b. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service.

The date of service is the date you receive the service or supply. You must actually receive the service or supply before we will pay the claim.

Usually, you can show your Delta Dental ID card to the provider, and they will bill us for you. We will pay the provider and send a copy of our payment record to you. The provider will then bill you for any charges that were not covered.

7.1.1 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). We may pay claims, deny them or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 7.1.

7.1.2 Claim Inquiries

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

7.1.3 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

- a. If the claim is denied, we will send an EOB explaining the denial
- b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it.
- c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information.

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 7.1.

7.2 APPEALS

Before you file an appeal, call Customer Service. We may be able to resolve your problem over the phone.

7.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

- a. You have **180 days** from the date you receive an adverse benefit determination to send us your first level appeal
- b. You have **60 days** from the date of the first level appeal decision to send us your second level appeal

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see “Filing an Appeal” in Section 11). Describe what happened and what outcome you are hoping for. Include dental records or other documentation that will help us investigate your appeal.

7.2.2 The Review Process

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

You may review the claim file and submit written comments, documents, records and other information to support your appeal.

How First and Second Level Appeals Work

- a. Submit your appeal in writing, on time. If you need help, ask Customer Service
- b. Someone who was not involved in the original decision will investigate your appeal
- c. We will send the decision to you within 30 days

Special Circumstances

The timelines for reviewing your appeal do not apply if:

- a. You do not reasonably cooperate
- b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises

You must go through the first and second levels of appeal before you can sue under ERISA Section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights.

7.2.3 Definitions

For purposes of section 7.2, the following definitions apply:

Adverse Benefit Determination is a letter or an Explanation of Benefits (EOB) from us telling you that you are not eligible for benefits or that benefits have not been fully paid. Reasons are:

- a. Eligibility to participate in the Plan
- b. Utilization review (described below)
- c. Limitations or exclusions described in Section 4 or Section 6 including a decision that an item or service is experimental or investigational or not dentally necessary

Appeal is a written request by you or your representative for us to review an adverse benefit determination.

Utilization Review is how we review the dental necessity, appropriateness or quality of dental care services and supplies. These adverse benefit determinations are examples of utilization review decisions:

- a. The care is not dentally necessary or appropriate
- b. The care is investigational or experimental
- c. The decision about whether a benefit is covered involved a dental judgment

7.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

7.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have dental coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then any other plans pay. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first.

COB can be very complicated. This is a summary of some of the more common situations where you may have double coverage. It is not a full description of the COB rules. If your situation is not described here, contact Customer Service for more information.

7.3.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

- a. The subscriber's own dental expenses
- b. Your covered child's expenses when you are the subscriber and
 - i. Your birthday falls earlier in the year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
 - ii. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
 - iii. If you are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

7.3.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses

- a. We will calculate the benefits we would have paid if you did not have any other dental coverage. We will apply that amount to any allowable expense that the primary plan did not pay
- b. We will credit any amounts to the deductible that would have been applied if you did not have other dental coverage
- c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
- d. If the primary plan did not cover an expense you did not follow that plan's rules, we will not cover that expense either. An example is if you have a lower benefit from your primary plan because you did not use an in-network provider

If the primary plan is a closed panel plan (HMO is an example) and you use an out-of-network provider, we will provide benefits as if we are the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Any plan that does not follow Oregon's COB rules is always primary.

7.3.1.3 Definitions

For purposes of section 7.3.1, the following definitions apply:

Plan is any of the following that provide benefits or services for medical or dental care or treatment:

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

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.

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 does not include:

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

Allowable expense is a dental expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

These are not allowable expenses:

- a. Any expense is not covered by any plan covering you
- b. Any expense a provider is not allowed to charge you

7.3.2 Third Party Liability

The rules for third party liability, including motor vehicle and other accidents, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

The Plan does not cover benefits when someone else (a third party) is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and agreement that the Plan is entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party.

You agree to do whatever is necessary to fully secure and protect the Plan's right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate with us to protect the Plan's subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect the Plan's rights and providing any information or taking any actions that will help us recover costs from a third party. We have discretion to interpret these recovery and subrogation provisions.

- a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for the Plan.
- b. The Plan is entitled to be reimbursed for any benefits the Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. The Plan is entitled to receive the amount of benefits the Plan has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.
- c. If this Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies under the Plan. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.
- d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 7.3.2.
- e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.
- f. Section 7.3.2 applies you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Delta Dental.

If you or your representatives do not comply with the requirements in this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any sickness, illness, injury or dental/medical condition related to the third party claim, except for claims related to motor vehicle accidents (see section 7.3.2.1). We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

7.3.2.1 Motor Vehicle Accident Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we will advance benefits. The Plan has the right to be repaid from the proceeds of any settlement, judgment or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If we require you or your attorney to protect the Plan's recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You will do whatever is required to secure, and may not prejudice, our rights under this section.

SECTION 8. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

8.1 SUBSCRIBER

You must give the Participating District a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Subscribers may become covered following the required days of employment as determined by the participating district.

To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You are eligible to enroll if you:

- a. are a permanent documented full time employee, sole proprietor, owner, business partner or corporate officer of the participating district
- b. are not a leased, seasonal, or substitute or temporary employee, or an agent, consultant, or independent contractor
- c. are paid on a regular basis through the payroll system, have federal taxes deducted from such pay, and are reported to Social Security
- d. work for the Participating District on a regularly scheduled basis at least the required hours per week as determined by the Participating District
- e. satisfy any orientation and/or eligibility waiting period

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

You must tell us and the Participating District if your address changes.

8.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (as defined in Section 10) is eligible for coverage. If a subscriber marries or enters a domestic partnership, the spouse or domestic partner and their children can enroll as of the date of the marriage or partnership.

If the marriage or partnership date is the first day of the month, coverage begins that day. Otherwise, coverage begins on the first day of the next month.

A subscriber's children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26. Foster children are eligible only while they are legally your foster child.

In this Plan, eligible children are:

- a. The biological, adopted or foster child of the subscriber or a subscriber's eligible spouse or domestic partner
- b. Children placed for adoption with the subscriber
- c. Your newborn child for the first 31 days of the newborn's life
- d. Children related to the subscriber and the subscriber is their legal guardian

Your newborn child is eligible from birth and coverage begins that day. A subscriber's adopted child, or child placed for adoption or as a foster child, is eligible on the date of placement. Their coverage begins on the date of adoption or placement. Court ordered coverage begins on the first day of the month after the date the Participating District determines that the order qualifies as a QMCSO, and that the child is eligible to enroll in the Plan. You must provide proof of legal guardianship for coverage of a grandchild beyond the first 31 days from birth. See section 8.4.3 to add your new child.

Children with Disabilities

A subscriber's child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even though they are over 26 years old. If the child is eligible for over-age coverage under the medical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, you must send us the medical carrier's determination that the child is eligible for over-age coverage to Delta Dental at least 45 days before the child's 26th birthday to avoid a break in coverage.

8.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered.

To add a new dependent to your coverage, submit:

- a. Complete and signed application
- b. Documentation. This may be a marriage certificate, domestic partnership documentation, birth certificate, or guardianship, adoption or placement for adoption or foster child placement paperwork

You must apply within 31 days of the new dependent becoming eligible. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums.

8.3 OPEN ENROLLMENT

If you are not enrolled within 31 days of first becoming eligible, you must wait for the next open enrollment period to enroll unless:

- a. You qualify for special enrollment as described in section 8.4
- b. A court has ordered you to provide coverage for a spouse or minor child under the subscriber's dental plan. You must enroll no more than 30 days after the court order is issued

Open enrollment occurs once a year at renewal. If you enroll during open enrollment, coverage begins on the date the Plan renews.

8.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

8.4.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other dental coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

- a. You stated in writing that you already had dental coverage when this Plan was first offered to you
- b. You ask to enroll no more than 31 days after your prior coverage ended
- c. You have a qualifying event. These are:
 - i. Your other coverage ended because you were no longer eligible. Examples of when this happens include:
 - A. loss of dependent status per plan terms, including divorce or legal separation
 - B. end of employment or not working enough hours
 - C. reaching the lifetime maximum on all benefits
 - D. the plan stops offering coverage to a specific group of similarly situated persons
 - E. moving out of an HMO service area and the plan does not have another option
 - F. the benefit package option is canceled, and no substitute option is offered
 - ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll.
 - iii. You exhausted your COBRA continuation coverage

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before the loss of other coverage.

8.4.2 Payment Changes

You may have special enrollment rights when there are changes to how your premiums are paid:

- a. Employer contributions toward your other active coverage (not COBRA coverage) end. You must ask for special enrollment no more than 31 days after the contributions end.
- b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before the premium contribution or subsidy change.

8.4.3 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, domestic partnership, birth, adoption or placement for adoption or as a foster child). You can enroll along with your new dependent. See section 8.4.

If coverage is waived for a child under 24 months, they may be added upon turning 2 years old.

8.4.4 The National Medical Support Notice

The Plan will cover persons deemed to qualify for medical support under the National Medical Support Notice (Notice). The Notice is a standardized medical child support order that is to be used by State child support enforcement agencies to enforce medical child support obligations. If the Plan Administrator determines that the Notice is appropriately completed, the Plan Administrator is required to treat the Notice as a QMCSO and must inform the State agency that issued the Notice when coverage under the plan of the child named in the Notice will begin and must provide the custodial parent of the child (or, in some cases, a named State official) with information about the child's coverage under the plan, such as the plan's summary plan description, any forms or documents necessary to make claims under the plan, etc.

8.5 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

8.5.1 The Group Plan or of a Participating District's Participation in the Plan

Coverage ends for the Group as a whole or Participating District and members on the date the Plan or participation in the Plan ends.

8.5.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, only at open enrollment or if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

8.5.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage if you meet the requirements for continuation of coverage (see Section 9).

8.5.4 Termination, Layoff or Reduction in Hours of Employment

When the subscriber's employment ends, coverage ends on the last day of that month unless you choose to continue coverage (see Section 9).

If you are laid off of work or your work hours are reduced, coverage ends on the last day of the month you were eligible. You can restart your coverage as if it had never ended if you are back at work and working the required hours within 6 months.

Coverage will restart on the date you meet eligibility requirements.

- a. You will not have to re-serve a waiting period
- b. Your premiums must be paid

8.5.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

- a. Coverage ends for an enrolled spouse or domestic partner on the last day of the month in which the marriage or partnership is legally ended (divorce, dissolution, annulment, etc.)
- b. Coverage ends for an enrolled child on the last day of the month in which
 - i. the child reaches age 26
 - ii. stepchild relationship ends due to divorce or end of domestic partnership
 - iii. legal guardianship or foster relationship ends

You must tell us when a marriage, domestic partnership, guardianship or foster child relationship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends (see Section 9).

8.5.6 Rescission

Rescission means canceling (rescinding) coverage back to the effective date, as if it had not existed. The Plan may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation.

Examples of fraud and material misrepresentation include but are not limited to:

- a. Enrolling someone who is not eligible
- b. Giving false information or withholding information that is the basis for eligibility or employment
- c. Submitting false or altered claims

The Plan has the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. You will be told of a rescission decision 30 days before your coverage is canceled.

SECTION 9. CONTINUATION OF DENTAL COVERAGE

Check with the Participating District to find out if you qualify for continuation coverage. You should read the following sections carefully.

9.1 55+ OREGON CONTINUATION

55+ Oregon Continuation applies to Participating Districts with 20 or more employees. It provides continuation coverage for spouses and domestic partners age 55 and older who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the following requirements:

You must tell the Participating District or its third party administrator within 60 days from the date your marriage or domestic partnership is legally ended or, within 30 days after the subscriber has died. Include your mailing address. You will be given information about how to sign up for continuation coverage and pay premiums.

If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise, 55+ Oregon Continuation ends when you become insured under any other group dental plan, you become eligible for Medicare or remarry or register another domestic partnership.

9.2 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Participating District to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Participating District or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, COBRA is available if you lose coverage because of:

- a. The subscriber's death
- b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Participating District are reduced
- c. The subscriber becomes entitled to Medicare
- d. Divorce or legal separation from the subscriber*
- e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the names of the Group and Participating District; 2) the name and social security number of the affected members; 3) the event (e.g., divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA

You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand delivered). The premium rate may include a 2% add-on to cover administrative expenses. All other payments are due on the 1st day of the month. You will not receive a bill. You are responsible for paying your premiums when due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA

COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of the subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family might be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period.

You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 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
- c. the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premium. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or 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 9.1).

When COBRA Ends

COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group or Participating District stops offering any group dental plan to its employees. COBRA will also end if:

- a. You become covered under another group dental plan
- b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's or Participating District's bankruptcy)
- c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud).

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**

A domestic partner does not have an independent election right under COBRA. If you are a covered domestic partner at the time of the qualifying event, the subscriber can include coverage for you when they elect COBRA. Your coverage ends when the subscriber's COBRA coverage ends (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

9.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Participating District. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Participating District.

9.4 FAMILY AND MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will restart as if there had been no break in coverage.

9.5 STRIKE OR LOCKOUT

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Participating District, to the union or trust. The union or trust must send the premiums to the Group 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. You become employed full-time with another employer
- c. You lose eligibility under the Plan for other reasons

SECTION 10. DEFINITIONS

Alveoloplasty is the shaping of the bone of the upper or the lower jaw. It is most commonly done in conjunction with the removal of a tooth or teeth so the gums heal smoothly for the placement of partial denture or full denture.

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

Anterior refers to teeth located at the front of the mouth (tooth chart in Section 12).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in Section 12).

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

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

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

Coinsurance is a percentage of covered expenses that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and we pay the other 80%.

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

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

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

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

Deductible is the amount of covered expenses you must pay before the Plan starts paying.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. References to Delta Dental as paying claims or issuing benefits means that Delta Dental processes a claim and the Plan Sponsor reimburses Delta Dental any benefit issued. Where this book refers to “we”, “us”, or “our” it is referring to Delta Dental or its employees.

Dentally Necessary means services that, in the judgment of Delta Dental:

- a. Are established as necessary for the treatment or to prevent a dental injury or disease otherwise covered under the Plan

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

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

Dentist is a licensed dentist operating within the scope of their license.

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

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

Domestic Partner means a person who has entered into a partnership with you that meets the participating employer's domestic partnership criteria.

Eligible Employee is an employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 8.1).

Emergency Services are services for a dental condition with acute symptoms of sufficient severity that requires immediate treatment. Includes services to treat acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

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

Group refers to Special Districts Insurance Services (SDIS), an association organized under Oregon laws to represent and serve the interests of its participating employers who employ a combined minimum of eligible employees enrolled according to the requirements of the Plan.

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

Implant Abutment is an attachment that connects an implant and an implant supported prosthetic device.

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

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

Maximum Plan Allowance (MPA) is the maximum amount the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the MPA is the dentist's filed or contracted fee with Delta Dental. For non-participating dentists or dental care providers, the MPA is based on the PPO fee schedule. When you use a non-participating dentist or dental care provider, you will have to pay any amount over the MPA.

Member is subscriber or dependent of a subscriber who is enrolled for coverage under the terms of the Plan. Where this book refers to "you" or "your" it is referring to a member.

Non-participating Dentist or Dental Provider is a licensed dental provider who has not agreed to Delta Dental's terms and conditions that participating Delta Dental Premier dentists have agreed to.

Participating Delta Dental Premier Dentist is a licensed dentist who has agreed to provide services in the Delta Dental Premier network in accordance with Delta Dental's terms and conditions and has satisfied Delta Dental that they are complying with such terms and conditions.

Participating District refers to an individual employer that:

- a. is considered a member company of the Group
- b. is considered a member in good standing
- c. is actively engaged in business which employs employees who are enrolled according to the requirements of the Group's Plan

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

Periodontal Maintenance is a periodontal procedure done when you have been treated for periodontal disease. This is a more comprehensive service than a regular cleaning (prophylaxis), where surfaces below the gum-line are also cleaned.

The **Plan** is the dental benefit plan sponsored and funded by the Group. Delta Dental is contracted to provide its claims and other administrative services.

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

Posterior refers to teeth located toward the back of the mouth (tooth chart in Section 12).

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

Prophylaxis is cleaning and polishing the visible surfaces of all teeth.

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

Restoration is treatment that repairs a broken or decayed tooth. Restorations include fillings and crowns.

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

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

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

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

SECTION 11. GENERAL PROVISIONS & LEGAL NOTICES

11.1 MISCELLANEOUS PROVISIONS

Contract Provisions

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

Confidentiality of Member Information

Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims. It is also used for referrals, case management and quality management programs. We do not sell your information. The Group's Notice of Privacy Practices has more detail about how we use your PHI. Contact the Group if you have other questions about privacy.

Right to Collect and Release Needed Information

You must give us, or authorize a provider to give us, any information we need to pay benefits. We may release to or collect from any person or organization any needed information about you.

Transfer of Benefits

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except to the provider.

Correction of Payments or Recovery of Benefits Paid by Mistake

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

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

Warranties

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

No Waiver

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

Group is the Agent

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

Responsibility for Quality of Dental Care

You always have the right to choose your dental provider. We are not responsible for the quality of your dental care. Your dentists act as independent contractors. We cannot control the detail, manner or methods by which a participating dentist provides care.

We cannot be held liable for the negligence of any dentist providing services to you. Nothing contained in the Plan shall be construed as obligating Delta Dental to provide dental services to you.

Provider Reimbursements

Dentists contracting with Delta Dental to provide services to you agree to look only to the Plan for payment of the part of the expense that is covered by the Plan. They may not bill you if the Plan fails to pay the dentist for whatever reason. The dentist may bill you for applicable cost sharing (such as coinsurance or deductible) or non-covered expenses except as may be restricted in the provider contract.

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.

Where any Legal Action Must be Filed

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

Time Limit for Filing a Lawsuit

Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 7.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

Notices

Any notice to you, to a provider or to the Group or Participating District that we are required to provide is considered properly given if written notice is deposited in the U.S. mail or with a private carrier. Notices will be addressed to the last known address in our records. If we receive a U.S. Postal Service change of address form, we will update our records with that new address. We

may forward a notice for you to the Group or Participating District if we become aware that we do not have a valid mailing address for you. Any notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

Filing an Appeal

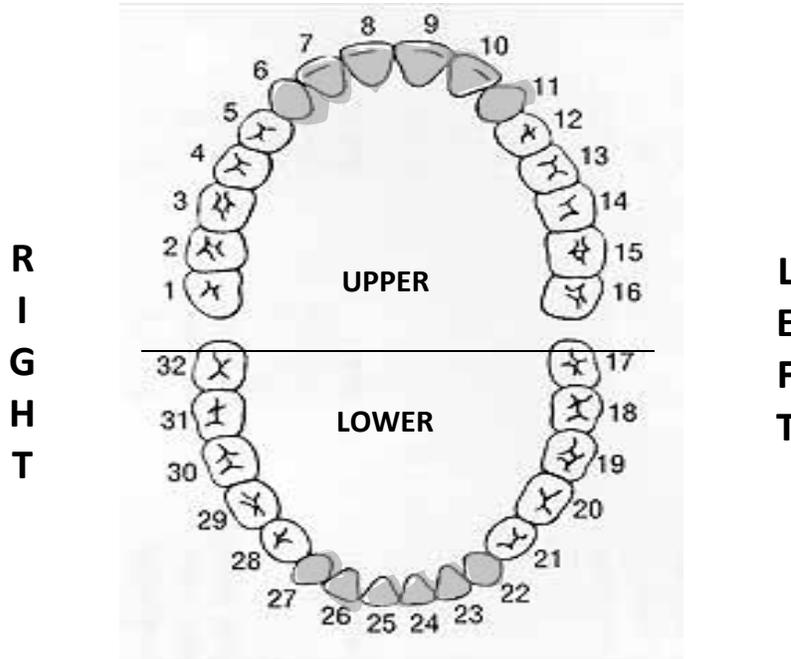
You can file an appeal or complaint by writing a letter to Delta Dental. Include the following information:

- a. Member name and date of birth
- b. Subscriber ID number
- c. Contact information (phone, email, mailing address)
- d. Provider(s) involved
- e. Date(s) of service
- f. Dental records from the provider, if applicable
- g. Reason for the appeal/complaint
- h. Description of what happened
- i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 7.2.

SECTION 12. TOOTH CHART

THE PERMANENT ARCH



Anterior teeth are shaded gray.

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

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint.

Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

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

[DeltaDentalAK.com](https://www.DeltaDentalAK.com) | [DeltaDentalOR.com](https://www.DeltaDentalOR.com)



For help, call us directly at 844-235-8018
(En español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240