Oregon
Group Dental Plan

KinderCare Education LLC
Delta Dental PPO Plan
Enhanced Plan with Orthodontia

Effective date: January 1, 2017
Group number: 10002970

Delta Dental of Oregon

Oregon Dental Service dba Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.
# TABLE OF CONTENTS

SECTION 1. WELCOME ........................................................................................................... 2  
  1.1 Member Resources ........................................................................................................ 2  
SECTION 2. USING THE PLAN ............................................................................................. 3  
SECTION 3. DEFINITIONS ..................................................................................................... 4  
SECTION 4. BENEFITS AND LIMITATIONS ......................................................................... 8  
  4.1 Class I: .......................................................................................................................... 8  
    4.1.1 Diagnostic ............................................................................................................... 8  
    4.1.2 Preventive ................................................................................................................. 9  
  4.2 Class II: ....................................................................................................................... 9  
    4.2.1 Restorative ............................................................................................................... 9  
    4.2.2 Oral Surgery .......................................................................................................... 10  
    4.2.3 Endodontic ............................................................................................................. 10  
    4.2.4 Periodontic ............................................................................................................. 10  
    4.2.5 Anesthesia ............................................................................................................. 11  
  4.3 Class III: ..................................................................................................................... 11  
    4.3.1 Restorative ............................................................................................................. 11  
    4.3.2 Prosthodontic ........................................................................................................ 11  
    4.3.3 Other ...................................................................................................................... 12  
  4.4 General Limitation – Optional Services ...................................................................... 13  
  4.5 Non-Participating Dentists ......................................................................................... 13  
  4.6 Participating Delta Dental Dentists............................................................................... 13  
SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM .............................................. 14  
  5.1 Oral Health, Total Health Benefits .............................................................................. 14  
    5.1.1 Diabetes ................................................................................................................ 14  
    5.1.2 Pregnancy .............................................................................................................. 14  
  5.2 How to Enroll ............................................................................................................. 14  
SECTION 6. EXCLUSIONS ................................................................................................. 15  
SECTION 7. ELIGIBILITY .................................................................................................... 18  
  7.1 Subscriber .................................................................................................................... 18  
  7.2 Dependents ................................................................................................................ 18  
  7.3 Qualified Medical Child Support Order (QMC SO) .................................................. 19  
  7.4 New Dependents ....................................................................................................... 19  
SECTION 8. ENROLLMENT .................................................................................................. 20  
  8.1 Enrolling Eligible Employees ...................................................................................... 20  
  8.2 Enrolling New Dependents ........................................................................................ 20  
  8.3 Open Enrollment ......................................................................................................... 20  
  8.4 Special Enrollment Rights ........................................................................................... 20
SECTION 9. CLAIMS ADMINISTRATION & PAYMENT ......................................................... 24

9.1 SUBMISSION AND PAYMENT OF CLAIMS ........................................................................ 24
9.1.1 Claim Submission ........................................................................................................ 24
9.1.2 Explanation of Benefits (EOB) .................................................................................. 24
9.1.3 Claim Inquiries .......................................................................................................... 24
9.1.4 Time Frames for Processing Claims .......................................................................... 24
9.2 APPEALS ......................................................................................................................... 24
9.2.1 Definitions .................................................................................................................. 24
9.2.2 Time Limit for Submitting Appeals ........................................................................... 25
9.2.3 The Review Process ................................................................................................... 25
9.2.4 First Level Appeals .................................................................................................... 25
9.2.5 Second Level Appeal ................................................................................................ 26
9.3 BENEFITS AVAILABLE FROM OTHER SOURCES .................................................... 26
9.3.1 Non-Duplication Provision ....................................................................................... 26
9.3.2 Third Party Liability ................................................................................................... 26

SECTION 10. NON-DUPLICATION PROVISION ..................................................................... 30

10.1 DEFINITIONS ................................................................................................................. 30
10.2 HOW NON-DUPLICATION WORKS ............................................................................. 31
10.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?) ..................... 32
10.4 NON-DUPLICATION PROVISION AND PLAN LIMITS .................................................. 33

SECTION 11. MISCELLANEOUS PROVISIONS................................................................. 34

11.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION .............................. 34
11.2 CONFIDENTIALITY OF MEMBER INFORMATION .................................................... 34
11.3 TRANSFER OF BENEFITS ............................................................................................. 34
11.4 RECOVERY OF BENEFITS PAID BY MISTAKE ......................................................... 34
11.5 CORRECTION OF PAYMENTS ..................................................................................... 34
11.6 CONTRACT PROVISIONS ............................................................................................... 35
11.7 WARRANTIES .................................................................................................................. 35
11.8 LIMITATION OF LIABILITY ........................................................................................... 35
SECTION 1. WELCOME

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

The Plan is self-funded and the Group has contracted with Oregon Dental Service (ODS), doing business as Delta Dental Plan of Oregon (abbreviated as Delta Dental) to provide claims and other administrative services. Delta Dental is part of Moda, Inc.

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

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

The Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Group may amend or terminate the Plan at any time by resolution of the Board or by any person or persons authorized by the Board to take such action.”

1.1 MEMBER RESOURCES

Moda Health Website (log in to myModa)
www.modahealth.com

Dental Customer Service Department
Toll-free 866-939-9197
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Delta Dental
P.O. Box 40384
Portland, Oregon 97240
SECTION 2. USING THE PLAN

Delta Dental plans are easy to use and cost effective. Participating Delta Dental PPO dentists contract to provide dental care to members. By using a participating Delta Dental PPO dentist, covered dental expenses will be paid at a higher rate. If members choose a contracted dentist from the Delta Dental PPO Directory (available on myModa by using “Find Care”), all of the paperwork takes place between Delta Dental and the dentist’s office. For travelers and employees outside Oregon, Delta Dental national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

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

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

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

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

This handbook describes the benefits of the Plan. It is the member’s responsibility to review this handbook carefully and to be aware of the Plan’s limitations and exclusions.
SECTION 3. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. A reference to Delta Dental as paying claims or issuing benefits means that Delta Dental processes the claim and the Group reimburses Delta Dental for any benefit issued.

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

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

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

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

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

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

a. **Registered Domestic Partner** means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.

b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group’s affidavit of domestic partnership.

**Eligible Employee** means any employee or former employee who meets the eligibility requirements to be enrolled on the Plan.

**Emergency** means services immediately required to relieve severe pain, swelling or bleeding, or required to avoid jeopardizing the member’s health.

**Enrollment Period** means the period in which a person is eligible to enroll for benefits under the terms of the Plan.

The **Group** is KinderCare Education LLC, the organization that has contracted with Delta Dental to provide claims and other administrative services. It also means the Plan Sponsor.

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

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

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

In-Network means only an Delta Dental Preferred Option provider or dentist.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a Delta Dental PPO dentist, the maximum amount is based on the PPO Fee allowable. For a dentist participating only on the Premier Plan, the maximum amount is the dentist’s filed or contracted fee with Delta Dental. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental’s Dental Consultant who determines a comparable code to the one billed. For non-participating dentists or dental care providers, the maximum amount is based on a per service average allowance of the participating Delta Dental Premier dentists’ filed or contracted fees. When using a non-participating dentist or dental care provider, any amount above the MPA is the member’s responsibility.

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

Non-participating Dentist or Dental Provider means a dental provider who has not contracted as a participating Delta Dental PPO provider or Delta Dental Premier dentist. By using one of these providers, covered dental expenses will be paid at the out-of-network rate shown in Section 4. Non-participating dental providers are reimbursed at the lesser of the maximum plan allowance and the dental provider’s actual billed fees, and are subject to member cost sharing.

Out-of-Network means any provider who is not an Delta Dental Preferred Option provider, including non-participating providers or dentists and participating Premier dentists.

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

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

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

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

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

Plan Sponsor means the Group.
Pontic is an artificial tooth that replaces a missing tooth and is part of a bridge.

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

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

Subscriber means any 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.
SECTION 4. BENEFITS AND LIMITATIONS

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

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist’s or dental care provider’s license, certificate or registration.

Benefits are determined based on a calendar year (January 1 through December 31) or portion thereof.

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

All “annual” or “per year” benefits or cost sharing accrue on a calendar year basis and frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

**Deductible:** $50
   - Per member (not to exceed $150 per family) per year, or portion thereof
   - For in-network benefits, deductible applies to covered Class II and Class III services
   - For out-of-network benefits, deductible applies to covered Class II and Class III services

**Maximum payment limit:** $2,000
   - Per member per year, or portion thereof

4.1 CLASS I:
**Covered services paid at 100% of the maximum plan allowance for in-network benefits and 100% for out-of-network benefits**

4.1.1 Diagnostic

a. **Diagnostic Services:**
   i. Examination
   ii. Intra-oral x-rays to assist in determining required dental treatment.

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

4.1.2 Preventive

a. Preventive Services:
   i. Prophylaxis (cleanings)
   ii. Periodontal maintenance
   iii. Topical application of fluoride
   iv. Space maintainers
   v. Sealants

b. Preventive Limitations:
   i. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period**†. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year.
   ii. Topical application of fluoride is covered once in any 6-month period* for members through age 19.
   iii. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth during any 5-year period.
   iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.

*These time periods are calculated from the previous date of service.
†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see Section 5).

4.2 Class II: Covered Services paid at 80% of the maximum plan allowance for in-network benefits and 80% for out-of-network benefits

4.2.1 Restorative

a. Restorative Services:
   i. Amalgam fillings and composite fillings for the treatment of decay
   ii. Stainless steel crowns

b. Restorative Limitations:
   i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.3.1.
iv. Replacement of a stainless steel crown by the same dentist within 24 months of placement is not covered. The replacement is included in the charge for the original crown.

4.2.2 Oral Surgery

a. Oral Surgery Services:
   i. Extractions (including surgical)
   ii. Other minor surgical procedures

b. Oral Surgery Limitations:
   i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
   ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
   iii. Brush biopsy is covered once in any 6-month period. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

4.2.3 Endodontic

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

b. Endodontic Limitations:
   i. A separate charge for cultures is not covered.
   ii. Pulp capping is covered only when there is exposure to the pulp.
   iii. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

4.2.4 Periodontic

a. Periodontic Services:
   i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

b. Periodontic Limitations:
   i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
   ii. Periodontal maintenance is covered under Class I, Preventive.
   iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
   iv. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.
4.2.5 **Anesthesia**

a. **Anesthesia Services:**
   General anesthesia or IV sedation is covered
   i. In conjunction with covered surgical procedures performed in a dental office
   ii. When necessary due to concurrent medical conditions

4.3 **Class III:**
**Covered services paid at 50% of the maximum plan allowance for in-network benefits and 50% for out-of-network benefits**

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 5-year period on any tooth. See section 4.2.1 for limitations on buildups.
   ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
   iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

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

b. **Prosthodontic Limitations:**
   i. A bridge or a full or partial denture will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 5 years.
   ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
   iii. Partial dentures: A temporary (interim) partial denture is not covered. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for
partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.

iv. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.

v. Tissue conditioning is covered no more than twice per denture in a 36-month period.

vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per tooth or tooth space in a 7-year period. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:
   A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in a 5-year period; or
   B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device; or
   C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in a 5-year period.
   D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
   E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 5 years.

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

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

4.3.3 Other

a. Other Services:
   i. Nightguard (Occlusal guard)
   ii. Orthodontia for correcting malocclusioned teeth

b. Other Limitations:
   i. A nightguard (occlusal guard) is covered once every 5 years at 50% up to $500 maximum. Over-the-counter nightguards are excluded.
   ii. Lifetime maximum of $2,500 per member for orthodontic services. This maximum is not included in the annual maximum payment limit. Any deductible is waived.
   iii. Payment for orthodontia will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the Plan. If treatment began before the member was eligible under the Plan, the Plan will base its obligation on the balance of the dentist’s normal payment pattern. The orthodontic maximum will apply to this amount.
iv. 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, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will be responsible for the remainder of the dentist’s fee.

4.5 Non-Participating Dentists

The amounts payable for services of a non-participating dentist or dental care provider are as described in the definition of Maximum Plan Allowance. Any amount above MPA is the member’s responsibility.

4.6 Participating Delta Dental Dentists

When using a participating Delta Dental dentist, payment will be in full, less member deductible and coinsurance.

By using a participating Delta Dental PPO dentist, covered dental expenses will be paid at the in-network rate. Payment to participating Delta Dental PPO dentists will be the lesser of the PPO Fee Schedule and the dentist’s actual billed fees.

Payment to a participating Delta Dental Premier dentist will be paid at the out-of-network rate, and will be based on the dentist’s filed or contracted fee with Delta Dental or fees actually charged, whichever is less.
SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

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

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

Delta Dental has developed a program that provides additional cleansings (prophylaxis or periodontal maintenance) for members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 4.1.2.

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

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

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

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

5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can complete and return the Oral Health, Total Health enrollment form found on myModa. Members with diabetes must include proof of diagnosis.
SECTION 6.  EXCLUSIONS

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

**Anesthesia or Sedation**
General anesthesia and/or IV sedation except as stated in section 4.2.5

**Anesthetics, Analgesics, Hypnosis, and Medications**
Including nitrous oxide, local anesthetics or any other prescribed drugs

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

**Claims Not Submitted Timely**
Claims submitted more than 12 months after the date of service, except as stated in section 9.1.1

**Congenital or Developmental Malformations**
Including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).

**Cosmetic Services**

**Duplication and Interpretation of X-rays**

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

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

**Gnathologic Recordings**

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

**Inmates**
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison
Instructions or Training
Including plaque control and oral hygiene or dietary instruction

Localized Delivery of Antimicrobial Agents

Missed Appointment Charge

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

Over the Counter
Over the counter occlusal guards and athletic mouthguards

Periodontal Charting

Precision Attachments

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, and periodontal splinting.

Self-Treatment
Services provided by a member to herself or himself

Services on Tongue, Lip, or Cheek

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

Services Otherwise Available
Including those services or supplies:

- a. compensable under workers' compensation or employer's liability laws
- b. provided by any city, county, state or federal law, except for Medicaid coverage
- c. provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 9.3.2)
**TMJ**
Treatment of any disturbance of the temporomandibular joint (TMJ)

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

**Treatment Before Coverage Begins**

**Treatment Not Dentally Necessary**
Including services:

a. not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. that are inappropriate with regard to standards of good dental practice
c. with poor prognosis
SECTION 7. ELIGIBILITY

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

7.1 SUBSCRIBER

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

a. is a permanent documented full time employee, sole proprietor, owner, business partner, or corporate officer of the Group
b. is not classified by the Group as a leased, seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor, whether or not such individual is subsequently determined by a government agency, by the conclusion or settlement of threatened or pending litigation, or otherwise to be or have been a common-law employee of the Group during the applicable coverage period
c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Group on a regularly scheduled basis at least 30 hours per week (25 hours per week for Champions)
e. has satisfied any orientation and/or eligibility waiting period

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

7.2 DEPENDENTS

A subscriber’s legal spouse or domestic partner is eligible for coverage. Legal spouse is defined as a lawful spouse, unless legally separated. A subscriber’s children are eligible until their 26th birthday, regardless of student status and including children of the same and opposite sex domestic partners.

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

a. The natural, adopted or foster child of a subscriber or a subscriber’s spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. 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

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

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

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

7.3 Qualified Medical Child Support Order (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

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

7.4 New Dependents

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration. If a subscriber files an Affidavit of Domestic Partnership with the Group, the unregistered domestic partner and his or her children are eligible for coverage. The subscriber must enroll the new dependents through the Group’s automated benefit enrollment system within 30 days of the date of the marriage, registration or filing.

A member’s newborn child, adopted child or a child placed with the subscriber pending the completion of adoption proceedings will be enrolled if a subscriber enrolls the child through the Group’s automated benefit enrollment system within 30 days of the new child’s births, adoption or placement. If the application is not received, the child will not be covered.

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. If payment is required but not received, the dependent will not be covered.
SECTION 8. ENROLLMENT

8.1 ENROLLING ELIGIBLE EMPLOYEES

Eligible employees must enroll through the Group’s automated benefit enrollment system for the eligible employee and any dependents to be enrolled. Eligible employees must enroll during their initial enrollment period as defined by the Group as a new hire or newly eligible employee. Refer to the Group’s Benefits Highlights brochure for details.

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

8.2 ENROLLING NEW DEPENDENTS

A subscriber may enroll newly acquired or newly eligible dependents through the Group’s automated benefit enrollment system within 30 days of their eligibility.

8.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 30 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless they meet one of the eligibility requirements described in section 8.4. Open enrollment occurs once a year at renewal.

8.4 SPECIAL ENROLLMENT RIGHTS

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

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

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

8.4.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other dental coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group dental plan or had dental coverage at the time
   coverage was previously offered
b. He or she requests such enrollment not later than 30 days after the previous coverage ended (except for event iv. below, which allows up to 60 days)

c. One of the following events has occurred:
   i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
   ii. His or her 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. the plan ceasing to offer coverage to a group of similarly situated persons
      G. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan
      H. termination of the benefit package option, and no substitute option is offered
   iii. The employer contributions toward his or her other coverage were terminated. (If employer contributions cease, the eligible employee or dependent does not have to terminate coverage under the prior plan to be eligible for special enrollment.)
   iv. His or her prior coverage was under Medicaid or a children’s health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

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

An eligible employee will need to enroll through the Group’s automated benefit enrollment system within the required timeframe. Refer to Group or www.kubenefits.com for details.

8.4.3 New Dependents
An eligible employee, spouse or domestic partner and children will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, domestic partnership, birth, adoption, or placement for adoption or as a foster child).

To enroll a new dependent, the subscriber must enroll through the Group’s automated benefit enrollment system within 30 days of the event.

8.5 When Coverage Begins
Coverage will become effective the first of the month following 30 days of employment for all employees of all divisions.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group begins on the first day of the month following the date the subscriber confirmed changes in the automated enrollment system.
Coverage for a newborn is effective on the date of the newborn’s birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

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

8.6 WHEN COVERAGE ENDS

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

8.6.1 Termination of the Group Plan
Coverage ends for the Group and members on the date the Plan ends.

8.6.2 Termination by Subscriber
A subscriber may terminate his or her coverage, or coverage for any enrolled dependent. Refer to the Group or www.kubenefits.com for details. If a subscriber terminates his or her own coverage, coverage for any dependents also ends at the same time.

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

8.6.4 Termination, Layoff or Reduction in Hours of Employment
Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see Section 12).

After a subscriber becomes covered under the Plan, if employment ends and he or she is rehired by the Employer Plan Sponsor or Participating Employer within 13 weeks after the termination date, coverage will take effect on the first day of the month following the subscriber’s latest start date. If coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and Plan maximums.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage.

The Plan must notify Delta Dental that a subscriber’s hours have been increased, and the necessary premiums for coverage must be paid.

8.6.5 Loss of Eligibility by Dependent
Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that the partnership no longer meets the requirements of the Affidavit of Domestic Partnership. Coverage ends for an enrolled child on the last day of the month in which the child reaches age 26.
Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends.

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

8.6.7 Continuing Coverage
Information is in Continuation of Dental Coverage (Section 12).
SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION AND PAYMENT OF CLAIMS

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

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

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

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

9.1.4 Time Frames for Processing Claims
If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond Delta Dental’s control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then complete its processing and send an EOB to the member no more than 45 days after receiving the claim. If additional information is needed to complete processing of the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan’s claim submission period explained in section 9.1.1.

9.2 APPEALS

9.2.1 Definitions
For purposes of section 9.2, the following definitions apply:

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

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

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

### 9.2.2 Time Limit for Submitting Appeals

Members have **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeal process will be lost. In addition, the right to file suit in court may be lost, as the member will have failed to exhaust his or her internal appeal rights, which is generally a prerequisite to bringing suit.

### 9.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. Delta Dental’s response time to an appeal is based on the nature of the claim as described below. These 2 levels of review must be exhausted before a member can exercise the right to file a lawsuit in court under ERISA Section 502(a).

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

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

### 9.2.4 First Level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Delta Dental will conduct an investigation by persons who were not previously involved in the original determination. The investigation will be completed and notice sent within 30 days of receipt of the appeal.

When an investigation has been completed, Delta Dental will send a written notice of the decision to the member, including the basis for the decision. If applicable, the notice will include information on the right to a second level appeal.
9.2.5 Second Level Appeal
A member who disagrees with the decision regarding the first level appeal may request a review of the decision. A second level appeal must be submitted in writing within 60 days of the date of Delta Dental’s action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will follow the same timelines outlined in section 9.2.4. Delta Dental will notify the member in writing of the decision, including the basis for the decision, and, if applicable, information on the right to file suit under ERISA Section 502(a).

9.3 Benefits Available from Other Sources

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

9.3.1 Non-Duplication Provision
This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation is in Section 10.

9.3.2 Third Party Liability
A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member’s expenses based on the understanding and agreement that the Plan is entitled to be reimbursed in full from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in section 9.3.2. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan’s right of recovery or subrogation as discussed in this section. The Plan has discretion to interpret and construe these recovery and subrogation provisions.

9.3.2.1 Definitions:
For purposes of section 9.3.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

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

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

9.3.2.3 Right of Recovery
In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply:

a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.

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

c. The Plan is not responsible for and will not pay any fees or costs associated with the member pursuing a claim against a third party. The Plan is entitled to full reimbursement, without discount and without reduction for attorney fees and costs. Neither the “made-whole” rule nor the “common-fund doctrine” rule applies under the Plan.

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

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.
f. In third party claims involving the use or operation of a motor vehicle, the Plan, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538, or under applicable state law.

### 9.3.2.4 Additional Provisions

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

a. The member shall cooperate with Delta Dental to protect the Plan’s recovery rights, including by:

   i. Signing and delivering any documents Delta Dental reasonably requires to protect the Plan’s rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned.

   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 9.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.

   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member’s provider.

   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing the Plan’s third party recovery rights.

b. The member and his or her representatives are obligated to notify Delta Dental in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.

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

d. The member agrees that Delta Dental may notify any third party, or third party’s representatives or insurers, of the Plan’s recovery rights described in section 9.3.2.

e. Even without the member’s written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 9.3.2.

f. Section 9.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member’s injuries occurred before the member became covered by the Plan.
g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member’s representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim. Delta Dental may notify dental/medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has dental/medical coverage under more than one plan or health insurance policy) is not considered a third party claim.
SECTION 10. NON-DUPLICATION PROVISION

This provision applies to this Plan when you or your covered dependent have health care coverage under more than one Plan. 'Plan' and 'This Plan' are defined below.

10.1 DEFINITIONS

For purposes of Section 10, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service 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, or because the member has a lower benefit due to not using an in-network provider

b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology

c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees

d. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan’s arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit 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.

If a plan benefit has a visit limitation (such as cast restoration and prosthodontal benefits) and the limitation has been met, services in excess of the limitation will not be considered covered expenses for the purpose of this provision.

This Plan is the part of this group health plan funded by the Group that provides benefits for dental expenses.

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

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

10.2 How Non-Duplication Works

If the member is covered by another plan or plans, this Plan will not pay for covered expenses to the extent that the member has any other coverage for those expenses if the other plan:

- Does not include a Coordination of Benefits (COB) or non-duplication provision, or
- Includes a Coordination of Benefits or non-duplication provision and is the primary plan as compared to this Plan.
10.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

When another plan does not have a COB or non-duplication provision, that plan is primary, and therefore determines and pays its benefits first. When another plan does have a COB or non-duplication provision, 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 or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the ‘Birthday Rule’.)

c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:

   i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

   ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the ‘birthday rule’ described above applies.

   iii. If there is not a court decree allocating responsibility for the child’s healthcare expenses, the order of benefits is as follows: The plan covering the

      A. Custodial parent
      B. Spouse or domestic partner of the custodial parent
      C. Non-custodial parent
      D. Spouse or domestic partner of the non-custodial parent

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

e. **Dependent Child Covered by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents’ plans and the spouse’s plans began on the same day, the birthday rule will apply.

f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, 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.

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

h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

### 10.4 **Non-Duplication Provision and Plan Limits**

If this non-duplication provision reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.
SECTION 11. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental nor the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider upon a member’s written request.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

11.5 CORRECTION OF PAYMENTS

If another plan makes payments this Plan should have made under this non-duplication provision, the 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.

If the Plan makes payments that should have been made by another plan, it will have the right to recover them from the person to or for whom they were made, or from insurance companies or other organizations. The person involved must sign any documents that are necessary to enforce the Plan’s rights under this provision.
11.6 CONTRACT PROVISIONS

The agreement between the Group and Delta Dental including 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.

11.7 WARRANTIES

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

11.8 LIMITATION OF LIABILITY

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

11.9 PROVIDER REIMBURSEMENTS

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

11.10 INDEPENDENT CONTRACTOR DISCLAIMER

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

**11.11 NO WAIVER**

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

**11.12 GROUP IS THE AGENT**

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

**11.13 GOVERNING LAW**

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

**11.14 WHERE ANY LEGAL ACTION MUST BE FILED**

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

**11.15 TIME LIMITS FOR FILING A LAWSUIT**

Any legal action arising out of, or related to, the Plan and filed against 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 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.
SECTION 12. CONTINUATION OF DENTAL COVERAGE

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

12.1 COBRA CONTINUATION COVERAGE

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

a. Other than an exception for domestic partner coverage, the Plan will offer no greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the notice, election or other requirements outlined below

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

12.1.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment), or a reduction in hours.

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

a. Death of the subscriber
b. Termination of the subscriber’s employment (for reasons other than gross misconduct) or reduction in the subscriber’s hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare

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

Children. A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:
a. Death of the subscriber
b. Termination of the subscriber’s employment (for reasons other than gross misconduct) or reduction in the subscriber’s hours of employment with the Group
c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a "child " under the Plan

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.

Retirees. If the Plan provides retiree coverage and the subscriber’s former employer files a chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

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

12.1.4 Notice and Election Requirements
Qualifying Event Notice. A dependent member’s coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse’s coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

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

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

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage 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.
If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

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

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

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

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

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

12.1.7 Extending the Length of COBRA Coverage
If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member fails to provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber’s termination of 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 member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

A member must provide the COBRA Administrator a copy of the Social Security Administration’s determination within the 18-month period following the subscriber’s termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration’s determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

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

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

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

12.1.8 Newborn or Adopted Child
If, during continuation coverage, a child is born to or placed for adoption or as a foster child with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (e.g., age). The subscriber or a family member must notify the COBRA Administrator within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the COBRA Administrator in a timely fashion, the child will not be eligible for continuation coverage.
12.1.9 Special Enrollment and Open Enrollment
Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners as covered dependents in accordance with the Plan’s eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.1.10 When Continuation Coverage Ends
COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time
b. a member becomes covered under another group dental plan
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. the Group ceases to provide any group dental plan for its employees
e. during a disability extension period (section 12.1.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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

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

12.2 Uniformed Services Employment & 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 31 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 31 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 military service for a leave of 31 days or less
b. Within 14 days of completing military service for a leave of 32 to 180 days
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. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

12.3 Family and Medical Leave

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

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

12.4 Extended Medical Leave of Absence

During an approved extended medical leave, coverage through the group plan will cease on the last day of the month in which the leave begins. A subscriber may continue coverage through COBRA continuation for the duration of the leave provided the subscriber was covered by the Group prior to the leave start date. Upon return from a medical leave, the subscriber must re-enroll in coverage by enrolling through the Group’s automated benefit enrollment system within 30 days of the return to work date. Coverage will be effective the first of the month following return from leave and completion of the enrollment process as defined by the Group. If the subscriber returns to work within 30 days of the benefit coverage ending, coverage will automatically be reinstated on the first of the month following return from leave.
SECTION 13.  ERISA DUTIES

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should check with the Group to determine if this section is applicable.

13.1  PLAN ADMINISTRATOR AS DEFINED UNDER ERISA

Delta Dental is not the plan administrator or the named fiduciary of the Plan, as defined under ERISA. Contact the Group for more information.

13.2  INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Group’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Group may make a reasonable charge for the copies.

Subscribers are entitled to receive a summary of the Plan’s annual financial report, if any is required by ERISA. The Group is required by law to furnish each subscriber with a copy of this summary annual report.

13.3  CONTINUATION OF GROUP DENTAL PLAN COVERAGE

Subscribers are entitled to continue dental care coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

13.4  PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent him or her from obtaining a benefit or exercising rights under ERISA.
13.5 **ENFORCEMENT OF RIGHTS**

If a claim for benefits is denied or no action is taken, in whole or in part, members have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report is requested by the Group and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 9.2). In addition, a member who disagrees with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

If plan fiduciaries misuse the Plan’s money, or if a member is discriminated against for asserting his or her rights, the member may seek assistance from U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the member is successful, the court may order the person who has been sued to pay these costs and fees. If the member loses, the court may order him or her to pay these costs and fees, (e.g., if it finds the claim is frivolous).

13.6 **ASSISTANCE WITH QUESTIONS**

For questions about Section 13 or a member’s rights under ERISA, or for assistance obtaining documents from the Group, members should contact one of the following:

- Employee Benefits Security Administration  
  Seattle District Office  
  300 Fifth Avenue, Suite 1110  
  Seattle, Washington 98104  
  206-757-6781

- Office of Outreach, Education and Assistance  
  US Department of Labor  
  200 Constitution Avenue N.W.  
  Washington D.C., 20210  
  866-444-3272

Information and assistance is also available through their website: dol.gov/ebsa Members may also obtain publications about their rights and responsibilities under ERISA by calling the Office of Outreach, Education and Assistance.
SECTION 14. TOOTH CHART

THE PERMANENT ARCH

Anterior teeth are shaded gray.

<table>
<thead>
<tr>
<th>The Permanent Arch</th>
<th>Description of Tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upper</td>
</tr>
<tr>
<td>Upper</td>
<td>1  17</td>
</tr>
<tr>
<td></td>
<td>2  18</td>
</tr>
<tr>
<td></td>
<td>3  19</td>
</tr>
<tr>
<td></td>
<td>4  20</td>
</tr>
<tr>
<td></td>
<td>5  21</td>
</tr>
<tr>
<td>Lower</td>
<td>6  22</td>
</tr>
<tr>
<td></td>
<td>7  23</td>
</tr>
<tr>
<td></td>
<td>8  24</td>
</tr>
<tr>
<td></td>
<td>9  25</td>
</tr>
<tr>
<td></td>
<td>10 26</td>
</tr>
<tr>
<td></td>
<td>11 27</td>
</tr>
<tr>
<td></td>
<td>12 28</td>
</tr>
<tr>
<td></td>
<td>13 29</td>
</tr>
<tr>
<td></td>
<td>14 30</td>
</tr>
<tr>
<td></td>
<td>15 31</td>
</tr>
<tr>
<td></td>
<td>16 32</td>
</tr>
</tbody>
</table>
Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:
Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:
Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:
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).
Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda’s efforts to assure nondiscrimination are coordinated by:
Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 15019019 (8/16)
ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

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

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

TUONG: Đầu chữ ký bằng tiếng Việt có dịch vụ trợ trợ ngôn ngữ miễn phí cho bạn.
Gọi 1-877-605-3229 (TTY: 711)

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

HUBACHIISA: Yoo afoan Kshtik kan dubbattan ta’e tajajilooni gargaarsaa isinif jira 1-877-605-3229(TTY:711) tiin bilbila.
For help, call us directly at 866-939-9197
(En Español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240

modahealth.com