PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

Part-time/Retiree Dental Plan

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

Administered by Oregon Dental Service.

Oregon

Theodore R. Kulongoski, Governor

January 1, 2008

TO: **State Employees**

FROM: **Public Employees' Benefit Board (PEBB)**

The benefits described on the following pages are designed to provide you and your family members with additional information about your coverage with Oregon Dental Service.

If you need additional information about this dental plan, please contact the insurance company at 1-800-452-1058 or PEBB at (503) 373-1102 or 1-800-788-0520.

Public Employees' Benefit Board

775 Court Street, NE

Salem, OR 97301-3802

(503) 373-1102

FAX (503) 373-1654

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BENEFITS PLAN DESCRIPTION

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

Telephone Numbers

Member Inquiries

Portland (503) 265-5680
Toll Free 1-800-452-1058
TDD/TTY 1-800-433-6313
(for the hearing and speech impaired)

Spanish Dental Customer Service
(Servicio al Cliente Area Dental)

Portland (503) 265-2963
Toll Free 1-877-299-9063
(llamado gratis)

Dental Office Inquiries

Portland (503) 243-4494
Toll Free 1-800-452-1058

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

How To Use Your Program

Welcome to Oregon Dental Service (ODS).

The Plan is self-funded and your employer has contracted with Oregon Dental Service to provide claims and other administrative services.

In this booklet, the terms, "you" and "your" refer to the covered employee. The terms "we", "us", and "our", refer to Oregon Dental Service (ODS) the Claims Administrator of the Plan.

As an Oregon Dental Service Dental Subscriber you have one of the finest prepaid dental care programs available. Services are provided by Participating Dentists who are available to assure good dental health. More than 95% of the licensed, practicing dentists in Oregon are actively participating in this program.

Visit the dental provider of your choice. During your first appointment, tell your dental provider that you have dental benefits through ODS. Give *your* subscriber number and ODS group number to the dentist. Your dental provider will perform an examination and may submit a treatment planning form to ODS to determine what part of the provider's bill you will have to pay.

You may choose a dentist from the ODS Premier Dental Directory (which is also available on the ODS website at www.odscompanies.com under "Provider Search").

Please review your handbook carefully. It describes the benefits of your plan. It is the responsibility of the member to review his or her plan and to be aware of its limitations and exclusions.

BEFORE TREATMENT IS STARTED, be sure you discuss with your dental provider the total amount of the fee and the portion you will be required to pay. Remember, the total allowable benefit for each covered person per year is $1,250.00. There is no form for you to obtain. The treatment planning form your dentist submits is all that is necessary. Sign this form to indicate that you are in agreement with the treatment your dental provider has decided upon. The standard ODS treatment planning form will be submitted by your dental provider.

All incoming treatment plans are subject to review to assure that actual charges made by the dental provider do not exceed his or her usual fees on file with ODS. We believe that the underlying unique feature inherent in all ODS programs consists of the dental profession's self-imposed discipline. Every Participating Dental Provider becomes a party to the control of cost and quality of care.

Please Note: While an eligible person may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

NOTE:
If you have any questions about the program, contact the Public Employees' Benefit Board at (503) 373-1102 or toll-free 1-800-788-0520, or call the ODS Dental Customer Service Department at (503) 265-5680 in the Portland area or toll-free 1-800-452-1058.

Definitions

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

Abutment is a tooth used to support a prosthetic device (implant crowns, bridges, partial dentures or overdentures).

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

Alveolar Structures are the upper and lower jaw bones.

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

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

Anterior refers to teeth located at the front of the mouth. (see tooth chart)

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

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

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

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

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

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

Claim Determination Period means a calendar year (January 1 through December 31) or portion thereof. Please see Claim Submission on page 38 for time limits for filing a claim.

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

Coinsurance means the relative percentages to be paid by the eligible person.

Covered Employee means an employee for whom the Policyholder has made contributions to provide dental benefits.

Covered Employment means employment for which an employer has made contributions to provide dental care benefits.

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

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

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

Dentally Necessary means:

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

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

Eligibility Date means the date an employee's or dependent's eligibility for benefits becomes effective under the terms of this Policy.

Eligible Dependent Or Family Member means any family member of an employee who is eligible for benefits in accordance with the conditions of eligibility outlined in this Policy.

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

Eligible Person means any employee or dependent who meets the conditions of eligibility outlined in this Policy. For the purposes of this Policy, an eligible person includes an individual who has made premium payments to continue coverage under the Policy.

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

Group Eligibility Waiting Period means the period of membership with the Group that prospective Enrollees must complete before coverage begins. Group's administrative rules govern the application of this provision.

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

Maximum Plan Allowance means:

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

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

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

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

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

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

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

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

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

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

Periodontal Maintenance is a periodontal procedure for patients 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** refers to the benefits and services available to an enrolled employee, as adopted by the PEBB Board. This Plan is a group dental plan.

Plan Sponsor is PEBB who has contracted with Oregon Dental Service to provide claims and other administrative services.

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

Policy means this agreement between ODS and the Policyholder including the application of the Policyholder for this Policy and the attached exhibits, appendices, amendments, endorsements and riders, if any. This Policy constitutes the entire Policy between the parties.

Policyholder means the Public Employees' Benefit Board for whose members or employees dental benefits are being provided.

Policy Term means the period commencing on the effective date hereof and continuing until the termination date as herein provided.

Policy Year means the 12-month period from January 1st through December 31st each year.

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

Posterior refers to teeth located toward the back of the mouth. (see tooth chart)

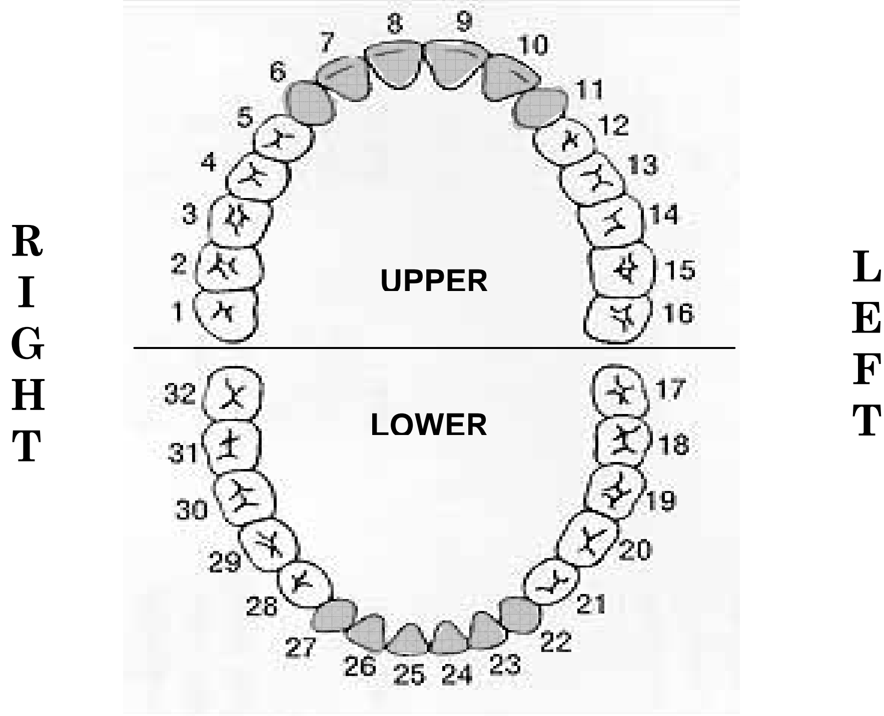
Prophylaxis is cleaning and polishing of all teeth.

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

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

Waiting Period means the period that must pass for certain individuals before the individual is eligible for benefits under the terms of the Plan. Please also see the Eligibility Section for further clarification.

Tooth Chart – The Permanent Arch



Note: Anterior teeth are shaded gray.

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

Eligibility

The Public Employees' Benefit Board (PEBB) eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees should refer to the PEBB Eligibility Handbook for detailed information on eligibility and program requirements.

SPECIAL RULES REGARDING DENTAL INSURANCE

1. Employees participating in the PEBB Program are required to enroll in employee only dental coverage.

2. Employees may enroll eligible family members in dental coverage. The family members enrolled in dental coverage do not have to match the family members enrolled in medical coverage. Employees may enroll family members within 60 days of a qualified status change. The qualified status change and the requested enrollment must be consistent under IRS rules. Family members added due to a qualified status change are not subject to the waiting period limitations. (See #4 below).

3. Employees who opt out of medical coverage must enroll in employee only or in family dental coverage.

4. NOTE: The waiting period applies to coverage for eligible family members if you wait until an open enrollment period to enroll them; you remove family members from the dental policy of the employee who enrolled the individual when initially eligible for a period of 12 months or more and then re-enroll them during open enrollment; or you and your spouse or domestic partner are both eligible PEBB members enrolled individually on the dental plan, and only you cover your children, and the children are later enrolled on your spouse's or domestic partner's dental plan during open enrollment.

5. Employees who change from one dental plan to another during the open enrollment period or due to a move out of service area are not subject to the waiting period.

6. Employees whose family members involuntarily lose coverage on another group dental plan may add their family members to their dental plan within 60 days of loss of dental coverage. Individuals enrolled under this provision are not subject to the waiting periods.

Benefit Summary

Calendar year maximum	$1,250.00
Calendar year deductible per individual	$ 50.00

Service	Benefit Amount
Diagnostic & Preventive – Deductible applies Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	**100%**
Basic - Deductible applies Restorative Dentistry Oral Surgery Endodontics Periodontics	**50%**
Major - Deductible applies Bridges Dentures Crowns Cast Restoration	**50%**

Note: Late enrollees have a 12 month waiting period for Basic and Major services.

NON-PARTICIPATING DENTIST

A small percentage of the licensed, practicing dental providers in Oregon are not participating with ODS. Each dental provider has a right to make such a decision. If you receive treatment from a Non-participating Dental Provider, he or she should complete a standard treatment form for you, but may require that you submit it directly to ODS. The program requires that amounts payable for services of a Non-participating Dental Provider be limited to the applicable percentages specified in the Plan for corresponding services in the Non-participating Provider Fee Schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's Non-participating Dentist Allowance. Non-participating Dental Providers may charge more than the ODS allowable and you are responsible for the entire amount which exceeds the maximum plan allowance.

PAYMENT BASED ON ACTUAL FEES

The amount of payment for various services is listed on the previous page. The percentage is applied to the actual fees of the Participating Dentists. THESE FEES HAVE PREVIOUSLY BEEN FILED WITH, AND APPROVED BY ODS. THE DENTAL PROVIDER MAY NOT CHARGE THE PATIENT MORE THAN HIS OR HER PRE-FILED FEES.

Benefits and Limitations

Below is a general list of services your dental care program covers when performed by a dental provider (licensed dentist, certified denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, **please see below. Also, see page 17 for exclusions**.

Deductible: $50.00
Per patient per calendar year, or portion thereof
Deductible applies to all covered dental services

Maximum Payment limit: $1,250.00
Per eligible patient per calendar year, or portion thereof
All covered services (Diagnostic, Preventive, Basic and Major) apply to Maximum Payment Limit

I. 100% is provided toward covered Diagnostic and Preventive Services

A. Diagnostic

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

Diagnostic Limitations:

1. Periodic (routine) or comprehensive examinations or consultations are covered twice in a calendar year.
2. Complete series x-rays (full mouth) or a panoramic film is covered only once in any five (5) year period. This time period is calculated from the previous date of service.
3. Supplementary bitewing x-rays are covered once in a calendar year for children under 15 years of age and once in a two calendar year period for persons age 15 years of age and older.

4. A member may qualify for a higher x-ray frequency based on the dentist's assessment of the individual's oral health and risk factors. (The maximum frequency, available only by dentist assessment, is bitewings twice in a calendar year; complete series or panoramic once in a 3 year period.)
5. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
6. Only the following x-rays are covered by the plan: complete series or panoramic, periapical, occlusal, and bitewings.

B. Preventive

Prophylaxis (Cleanings)
Topical application of fluoride
Space maintainers
Sealants

Preventive Limitations:

1. Prophylaxis (cleaning) is covered only once per calendar year unless the dentist's assessment of the individual's oral heath and risk factors indicates the need for more frequent cleanings. (The maximum frequency, available only by dentist assessment, is four cleanings in a calendar year.) Refer to Class II Periodontal benefits for frequency and limitations on periodontal maintenance.
2. Topical application of fluoride is covered twice in a calendar year for all ages.
3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.
4. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for patients age 14 or over are not covered.

II. 50% is provided toward covered Basic Services

A. Restorative

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

Restorative Limitations:

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

B. Oral Surgery

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

Oral Surgery Limitations:

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

C. Endodontic

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

Endodontic Limitations:

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

D. Periodontic

Treatment of diseases of the gums and supporting structures of the teeth.

Periodontic Limitations:

1. Periodontal scaling and root planing is limited to once per quadrant in any twenty-four (24) month period.
2. Periodontal maintenance is not covered unless the dentist's assessment of the individual's oral heath and risk factors indicates the need. (The highest frequency, available only by dentist assessment, is four prophylaxis and/or periodontal maintenance, in a calendar year.)
3. A separate charge for post-operative care done within three (3) months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a three (3) year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within twenty-four (24) months.

III. 50% is provided toward covered Major Services.

A. Restorative

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

Restorative Limitations:

1. Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth. See Basic Services for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

B. Prosthodontic

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

Prosthodontic Limitations:

1. A bridge or denture (full or partial denture) will be covered only once in a seven (7) year period and only if the tooth or teeth involved have not received a cast restoration benefit in the past seven (7) years.

2. *Full, immediate and overdentures:* If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
3. *Partial dentures:* A temporary (interim) partial denture is only a benefit when placed within two (2) months of a recently extracted anterior tooth or for missing anterior permanent teeth of patients age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4. *Denture adjustments and relines:* A separate, additional charge for denture adjustments and relines done within six (6) months after the initial placement is not covered. Subsequent relines will be covered only once per denture in a twelve (12) month period. Subsequent adjustments are limited to two (2) adjustments per denture in a twelve (12) month period.
5. Tissue conditioning is covered no more than twice per denture in a 36-month period.
6. Surgical placement, removal of implants, or related services are not covered. We will benefit:
    - The final crown and abutment over a single implant. This benefit is limited to once per tooth in any seven-year period; or
    - Provide an alternate benefit per arch of a full or partial denture for the final prosthetic when the implant is placed to support a prosthetic device. The alternate benefit will apply to the frequency limitation (only once in any seven-year period) for prosthetic devices.
    - This benefit or alternate benefit is not provided if the tooth received a cast restoration benefit within the previous seven (7) years.
7. Fixed bridges or removable cast partial dentures are not covered for patients under age sixteen (16).
8. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

IV. General Limitation – Optional Services

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

Exclusions

The following services are exclusions and are not covered:

1. Procedures, appliances, restorations or other services which are primarily for cosmetic purposes.

2. The following are not covered:

   - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
   - Services which are provided by any city, county, state or federal law, except for Medicaid coverage; or
   - Services which are provided, without cost to the eligible person, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Policy.

3. The Plan does not cover:

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

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

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

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

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

8. Gnathologic recordings or similar procedures.

9. Dental services (work in progress) started prior to the date the individual became eligible for such services under the Policy.

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

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

12. Charges for missed or broken appointments.

13. Experimental procedures or supplies.

14. Services provided or supplies furnished after the date coverage ends, except for Major Services which were ordered and fitted while still eligible and then only if such items are cemented within thirty-one (31) days after individual eligibility ends. This provision is not applicable if the Policyholder transfers the Plan to another carrier.

15. General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.

16. Surgical placement or removal of implants. See Limitations.

17. Plaque control and oral hygiene or dietary instruction.

18. Claims submitted more than 15 months after the date of service.

19. Other services or supplies not specifically included in this Policy as covered dental services.

20 Services performed on the tongue, lip or cheeks.

21 Taxes.

Example Of How The Plan Pays

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

Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Co-pay	Paid	Pt. Resp.
1/01/05	D2150 Amalgam Filling	30	$120.00	$20.00**	$0.00	$20.00	$100.00	$20.00	$80.00	$20.00
1/01/05	D9215 Local Anesthesia	--	$50.00	$50.00*	$0.00	$50.00	$0.00	$0.00	$0.00	$0.00
Totals:	---	---	$170.00	$70.00	$0.00	$70.00	$100.00	$20.00	$80.00	$20.00

Total Out of Pocket Expense

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

Non-Participating Dentist

Dates	CDT/Category	Tooth	Total Charges	Disallowed/ Reason	Deduct	Provider Discount	Allowed	Co-pay	Paid	Pt. Resp.
1/01/05	D2150 Amalgam Filling	30	$120.00	$20.00**	$0.00	$0.00	$100.00	$20.00	$80.00	$40.00
1/01/05	D9215 Local Anesthesia	--	$50.00	$50.00*	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00
Totals:	---	---	$170.00	$70.00	$0.00	$0.00	$100.00	$20.00	$80.00	$90.00

Total Out of Pocket Expense

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

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

Coordination of Benefits (COB)

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

DEFINITIONS

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

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

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

Plan does not include:
- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Medicare supplement policies;
- Medicaid policies; or
- Coverage under other federal governmental plans, unless permitted by law.

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

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

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

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

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any Plan covering the claimant. When a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the claimant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a claimant is not an Allowable Expense.

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

- The amount of the reduction by the primary Plan because a claimant has failed to comply with the Plan provisions concerning second opinions or prior authorization of services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

This Plan is the part of this group contract that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental benefits is separate from This Plan. A contract may apply one COB provision to certain

benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a Plan that provides dental benefits to covered persons primarily in the form of services through a panel 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 a panel 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.

HOW COB WORKS

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

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

The Secondary Plan (the Plan(s) that pay(s) benefits after the Primary Plan) will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan shall provide benefits as if it were the primary Plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

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

- If this Plan is primary, it will provide its benefits first.
- If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan’s benefits. This plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.

- If the non-complying plan reduces its benefits so that the covered person receives less in benefits than s/he would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the covered person against the non-complying plan.

WHICH PLAN PAYS FIRST?

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a Plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that Plan will determine its benefits before a Plan which covers the person as a dependent. However, if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.
2. **Dependent Child/Parents Married or Living Together.** If the claimant is a dependent child whose parents are married or are living together whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. If both parents' birthdays are on the same day, the Plan that has covered the parent the longest is the primary Plan. (This is called the 'Birthday Rule'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married, then the following rules apply:
   - If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree.
   - If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody

without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.

- If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
  - The Plan covering the custodial parent;
  - The Plan covering the spouse of the custodial parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the spouse of the non-custodial parent.

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

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

8. **None of the Above.** If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

THE PLAN'S RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

Continuation of Coverage

Continuation of coverage under the PEBB program is governed under Chapter 101, Division 30 of the Oregon Administrative Rules. The following is a summary of continuation coverage for spouses aged 55 years or older, and continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). There may be additional continuation options available; employees should refer to the PEBB Eligibility Handbook for detailed information on continuation of coverage.

Coverage for Spouses Aged 55 Years or Older

The following is applicable to policies issued in Oregon to employers of 20 or more employees. If a legal spouse is age 55 or older and his or her eligibility for insurance ends due to legal separation, termination of marriage or your death, such spouse will be entitled to continue his or her coverage (including coverage for dependent children) under this Plan. Continuation under this section is not available for any dependent electing coverage under the Continuation of Coverage COBRA section if he or she does not follow the election procedures as listed below.

In order to be eligible for continued coverage the spouse must give written notice of the legal separation, termination of marriage or your death to the Plan Administrator within:

- Thirty days of the date of your death;
- Sixty days of the date of legal separation; or
- Sixty days of the date of entry of the divorce decree.

Within 14 days of receipt of the above notice, the Plan Administrator shall notify the legally separated, divorced or surviving spouse that coverage can be continued, and provide an election form to the spouse. The spouse must return the election form within 60 days after the Plan Administrator mails it. Failure of the spouse to exercise the election within 60 days of the notification shall terminate the right to continued benefits.

If the Plan Administrator fails to notify the legally separated, divorced or surviving spouse within the required 14 days, premiums shall be waived until the date notice is received by the spouse.

The monthly premium rate for continued coverage will be the monthly rate which would have been charged if the spouse was an Individual under this Plan plus the applicable premium for coverage of dependent children. Each monthly premium (except the initial premium) must be paid by the spouse to the Plan Administrator within 30 days of the premium due date. The initial premium must be paid by the

spouse to the Plan Administrator within 45 days of the date the election to continue coverage is made.

Coverage will be continued on a month-to-month basis until the earliest of:

- The date the legally separated, divorced or surviving spouse becomes covered under any other group health plan;
- The date the legally separated, divorced or surviving spouse becomes entitled to benefits under Medicare;
- The last day of the month that premiums were paid to us in the event of non-payment of premiums; or
- The date the Plan terminates or the date the employer terminates participation under this Plan.

Individual Dental Exchange Program

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Notice

The Plan will provide benefits only to those qualified beneficiaries who elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), subject to the following limitations: (i) the Plan will offer no greater COBRA rights than the COBRA statute requires, and (ii) the Plan will not be responsible for COBRA coverage if the covered employee or other qualified beneficiary does not comply with any of the notice, election or other requirements outlined below

Summary of your rights and obligations with respect to COBRA coverage is set forth in this section.

COBRA is a federal law requiring most employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health coverage if coverage is lost due to a qualifying event (see below). A qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the covered employee (or retired employee), the covered employee's spouse, and the dependent children of the covered employee.
A covered employee or the spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the employee does not.

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

COBRA continuation is administered by a Third Party Administrator. You can contact the Plan sponsor, the Public Employees' Benefit Board (PEBB) located at 775 Court Street NE in Salem, Oregon for more information. You can contact PEBB at (503) 373-1102 or 1-800-788-0520.

Qualifying Events for Covered employee

If you are an employee, you become a qualified beneficiary if you lose group coverage for any of the following reasons (qualifying events):

(1) A reduction in your hours of employment; or
(2) Your employment ends for any reason.

Qualifying Events for Covered Spouse or Partner

If you are the covered spouse or partner, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

(1) Death of the employee;
(2) Termination of the employee's employment or reduction in the employee's hours of employment;

(3) The employee becomes enrolled in Medicare (Part A, Part B, or both); or
(4) Divorce or legal separation from the employee or termination of your domestic partnership.

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

Qualifying Events for Covered Dependent Children

Your dependent children become qualified beneficiaries if they lose eligibility for group coverage for any of the following reasons (qualifying events):

(1) Death of the employee;
(2) Termination of the employee's employment or reduction in the employee's hours of employment;
(3) The employee becomes enrolled in Medicare (Part A, Part B, or both);
(4) The employee's divorce or legal separation, or termination of a domestic partnership; or
(5) The child ceases to qualify as a dependent child under PEBB eligibility.

Important Employee, Spouse or Partner, and Dependent Notification Requirements

Under the law, the employee or family member is responsible to inform the agency's payroll/personnel office or benefits office within 60 days of the following qualifying events:

(1) A divorce;
(2) A legal separation;
(3) A termination of domestic partnership; or
(4) A dependent child losing dependent status under PEBB eligibility.

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employer Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of the date coverage ends.

Election Period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the COBRA Administrator. The Administrator will notify qualified beneficiaries by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions, each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your policy during the COBRA time period has the right to elect Continuation Coverage. You, your spouse or domestic partner can elect continuation coverage for any combination of individuals who would otherwise lose coverage.

Under the law, you have 60 days from the date you would lose coverage due to a qualifying event or the date on your notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an employee or covered family member to change their plan choices upon experiencing a qualifying event. This means that not only is the employee or family member given the right to continue coverage under COBRA, but may also choose any medical or dental plan at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, rights to continue medical and dental insurance will end.

If you choose Continuation Coverage, PEBB is required to offer you coverage that is identical to the coverage provided under the group plan to similarly situated active employees and family members. Should coverage change or be modified for active employees, then the change or modification will be made to your coverage as well. COBRA participants will also be offered an annual open enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. If you add family members, the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length of Continuation Coverage

The law requires that you receive the opportunity to maintain Continuation Coverage from the time of the qualifying event for the following periods:

(1) Up to 18 months if you qualify due to termination or reduction in working hours;

(2) Up to 36 months in the case of losses of coverage due to an employee's death, divorce, or legal separation, termination of a domestic partnership, a dependent child ceasing to be a dependent under the terms of the Plan.

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

(3) Up to 10 years if you are the spouse or partner of a covered employee and you are 55 years of age or older and qualify due to death of a covered employee, divorce or legal separation, or termination of domestic partnership (ORS 743.600 - 743-602).

Extending The Length Of Cobra Coverage

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

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a covered employee's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

You must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. The premium for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

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

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

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

When Continuation Coverage Ends

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

(1) The State of Oregon no longer provides group medical and dental coverage to any of its employees;

(2) Any required premium for Continuation Coverage is not paid in a timely manner;

(3) A qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan that does not exclude or limit coverage for specific conditions solely because they are pre-existing condition(s) which apply to you or to a covered dependent (this does not apply to CHAMPUS or Tri-Care);

(4) A qualified beneficiary becomes covered (after the date of COBRA election) under Medicare.

(5) The Social Security Administration no longer considers you disabled under the provision of the disability extension, but COBRA coverage will not terminate earlier than the end of the original 18 month continuation period.

(6) A qualified beneficiary notifies the COBRA Administrator they wish to cancel COBRA continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you or your family members become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated while the limitation is in effect. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, PEBB may terminate your COBRA coverage.

Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the covered employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The employee or a family member must notify the Policyholder within 60 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Policyholder in a timely fashion, the child will not be eligible for continuation coverage.

Eligibility and Premiums

Qualified beneficiaries do not have to show they are insurable to choose Continuation Coverage. However, they must have been covered by the active group plan on the day before the event to be eligible for Continuation Coverage. An exception to this rule is if, while on Continuation Coverage, a baby is born to, adopted, or placed for adoption by a covered employee. The newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

A qualified beneficiary will have to pay all of the premium plus a 2% administration charge for Continuation Coverage. These premiums will be adjusted during the continuation period if the active employee premiums change. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the State of Oregon will charge 150% of the premium during the extended coverage period. Beneficiaries will be billed on a monthly basis for the premiums due. There is a maximum grace period of 30 days for payment of the regularly scheduled premium.

At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual portability plan provided by the same insurance carrier, as long as portability plans continue to be offered. You may contact the insurance carrier to enroll in a portability plan before, during, or following your COBRA continuation period. To qualify for a portability plan you must make application directly to the medical carrier within 63 days following the end of your Continuation Coverage or any time during your Continuation Period. Coverage on a portability plan will differ from the group plan and may exclude certain conditions or services offered under the group plan. Contact the carrier for further details. Conversion of the dental plan is limited.

Special Enrollment And Open Enrollment

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

Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Questions

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your COBRA rights at that time. If any covered individual does not understand any part of this summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at:

- (503) 373-1102 or (800) 788-0520 (outside Salem).
- inquiries.pebb@state.or.us
- http://pebb.das.state.or.us

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

TRADE ACT OF 2002

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

Second Election Period for Certain Trade-Displaced Individuals

Certain covered employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Covered employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

- They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- They must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and

- They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

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

Duration of COBRA Coverage Elected During the Special Second Election Period

COBRA coverage elected during the special second election period is not retroactive – coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

COBRA Tax Credit

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

Claims Administration and Payment

The following section explains how we treat various matters having to do with administering your claims.

SUBMISSION AND PAYMENT OF CLAIMS

Claim Submission

A claim must be submitted to our office within 90 days after the date of loss. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except in the absence of legal capacity, can a claim be valid if submitted more than 15 months from the date of service.

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

Explanation of Benefits (EOB)

Soon after you make a claim, ODS will report to you on the action taken by sending you a document called an Explanation of Benefits. The Explanation of Benefits (EOB) will indicate if a claim has been paid, denied, or accumulated toward satisfying the deductible. If all or part of a claim is denied, the reason for the action will be stated in the Explanation of Benefits.

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

Claim Inquiries

If you have any questions about how to file a claim, a claim in process, or our action taken on a claim, please call us at (503) 265-5680 or toll-free at 1-800-452-1058 or write to our Dental Customer Service Department. We will respond to your inquiry within 30 days of receipt.

APPEALS

Definitions

For purposes of this section, the following definitions apply:

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

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

- The specific reason or reasons for the benefit denial,
- Reference to the specific Plan provision on which the denial was based,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information.

Post-service claim means any claim for a benefit under a group health plan for care or services that have already been received by you.

Pre-service claim means any claim for a benefit under a group health plan that ODS must approve, in whole or in part, in advance of you obtaining care or services.

A "**claim involving urgent care**" means any claim for dental care or treatment with respect to which the application of the regular time periods to review a denial of a pre-service claim:

(A) Could seriously jeopardize your life or health or your ability to regain maximum function, or,

(B) In the opinion of a dentist with knowledge of your dental condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment.

Time Limit for Submitting Appeals

You have **60 days** from the date of an adverse benefit determination to submit an initial written appeal regarding an adverse determination. If an initial written appeal is not submitted within the timeframes outlined in this section, you will lose your rights to the appeals process.

The Review Process

The Plan has a two-level review process. The first level of review is called a First Level Appeal. The second level of review is a Second Level Appeal. ODS' response time to an appeal is based on the nature of the claim as described below.

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

- The time period is too long to accommodate the clinical urgency of the situation;
- The Enrollee 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.

First Level Appeals

You may request that ODS review an adverse benefit determination. Your request, called a First Level Appeal, must be in writing. If you need assistance on filing an appeal, contact ODS Dental Customer Service Department at (503) 265-5680 or toll-free at 1-800-452-1058 to discuss the issue, as it may be possible to resolve your situation with a phone call. You may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request, and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. ODS' response time to your appeal is based on the nature of the claim. Your appeal will be reviewed by persons not previously involved in your case.

An appeal related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. An appeal related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the appeal by the Plan, unless you fail to provide sufficient information for the Plan to make a decision. In this case, an appeal coordinator will notify you within 24 hours of receipt of the appeal of the specific information necessary to make a decision. You will have no less than 48 hours, to provide the specified information. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period provided you to submit the specified additional information.

The investigation of an appeal of a **pre-service claim** will be completed within 15 days of receipt of the appeal.

The investigation of an appeal of a **post-service claim** will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, we will send you a written notice of the decision on your appeal, including the basis for the decision. If applicable, the written notice will include your right to a Second Level Appeal.

Second Level Appeal

If you disagree with our decision regarding your First Level Appeal, you may request a review of the decision. Your Second Level Appeal must be made within 60 days of the date of our action on your First Level Appeal.

If you request a Second Level Appeal, you must submit your appeal in writing. Your Second Level Appeal will be reviewed by persons not previously involved in the review of your case. You will have the option to submit written comments, documents, records and other information related to you case that was not previously submitted.

Investigations and responses to your Second Level Appeal will follow the same timelines outlined under the First Level Appeal subsection. We will notify you in writing of the decision, including the basis for the decision.

BENEFITS AVAILABLE FROM OTHER SOURCES

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

Coordination of Benefits (COB)

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

Third Party Liability

An individual covered by the Plan may have a legal right to recover benefit or healthcare costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or healthcare costs were paid by the Plan. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist

coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the illness or injury. Should the Plan make an advance payment of Benefits, as described below, it is entitled to be reimbursed for any benefits paid by the Plan that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by the Plan through these recoveries help reduce the cost of premiums and providing benefits.

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

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

Definitions:

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

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

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

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

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

5. "Recovery Funds" means any amount recovered from a Third Party.

Subrogation

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

Under this sub-section, we may pursue the Third Party in the Plan's name, or in the name of the member. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan.

Right of Recovery

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

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

2. The Plan is entitled to receive the amount of Benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, the Plan disentitled to receive the

amount of Benefits it has paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.

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

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

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

6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by the Plan, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

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

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

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, in Third Party claims involving the use or operation of a motor vehicle, the Plan, at our 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.

Additional Third Party Liability Section Provisions

In connection with the Plan's rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following and agrees that we may do one or more of the following, at our discretion:

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

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

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

d. The Covered Individual shall cooperate with us to protect the Plan's recovery rights under this Section, and in addition, but not by way of limitation, shall:

    i. Sign and deliver such documents as we reasonably require to protect the Plan's rights;

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

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

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

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

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

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

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

k. Coordination of Benefits (where the Covered Individual has healthcare coverage under more than one Plan or health insurance policy) is not considered a Third Party Claim.

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

General Plan Information

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

REQUEST FOR INFORMATION

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

DISCLOSURE OF BENEFIT REDUCTION

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

CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of your protected health information is of extreme importance to the plan sponsor and to ODS. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. Your information is used for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. For more complete detail about how your plan sponsor uses your information, please refer to the Notice of Privacy Practices. ODS as the third party administrator is required to adhere to these same practices. If you have additional questions about the privacy of your information beyond that provided in the Notice of Privacy Practices, please contact your plan sponsor.

TRANSFER OF BENEFITS

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

RECOVERY OF BENEFITS PAID BY MISTAKE

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

WARRANTIES

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

LIMITATION OF LIABILITY

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

PROVIDER REIMBURSEMENTS

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

INDEPENDENT CONTRACTOR DISCLAIMER

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

NO WAIVER

Any waiver of any provision of this contract, or any performance under this contract, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of ODS in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

GROUP IS THE AGENT

The Group is your and your enrolled family members' agent for all purposes under this contract. The Group is not the agent of ODS.

GOVERNING LAW

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

WHERE ANY LEGAL ACTION MUST BE FILED

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

TIME LIMITS FOR FILING A LAWSUIT

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

RESCISSION BY INSURER

We may rescind your coverage, and/or the coverage of your covered dependents, back to your effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by you or your covered dependents. We reserve the right to retain premiums paid by you as liquidated damages, and you shall be responsible for the full balance of any benefits paid. Should we terminate coverage under this Section, we may deny future enrollment of you and your dependents under any self-funded or insured Oregon Dental Service contract or the contract of any of our affiliates.

Protected Health Information

Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), ODS may disclose de-identified summary health information to *PEBB* for purposes of modifying, amending or terminating this *Plan*. In addition, *ODS* may disclose protected health information (PHI) to *PEBB* in accordance with the following provisions of this *Plan* as established by *PEBB*:

(a) *PEBB* may use and disclose the PHI it receives only for the following purposes:
   1. Administration of the Plan; and
   2. Any use or disclosure as required by law.

(b) *PEBB* shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to *PEBB* with respect to such information.

(c) *PEBB* shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of *PEBB*.

(d) *PEBB* shall report to *ODS* any use or disclosure of PHI that is inconsistent with the provisions of this section of which the *Employer* becomes aware.

(e) *PEBB* shall make PHI available to *Participants* in accordance with the privacy regulations of HIPAA.

(f) *PEBB* shall allow *Participants* to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) *PEBB* shall provide *Participants* with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) *PEBB* shall make its internal practices, books and records relating to the use and disclosure of PHI received from *ODS* available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.

(i) *PEBB* shall, if feasible, return or destroy all PHI received from *ODS* and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) *PEBB* shall provide for adequate separation between *PEBB* and *ODS* with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of *PEBB* or designated individuals:

1. Benefit Manager;
2. Director of Operations;
3. PEBB's Designated Consultants; and
4. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

Further, *PEBB* shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for *PEBB* with regard to this *Plan*. In addition, *PEBB* shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

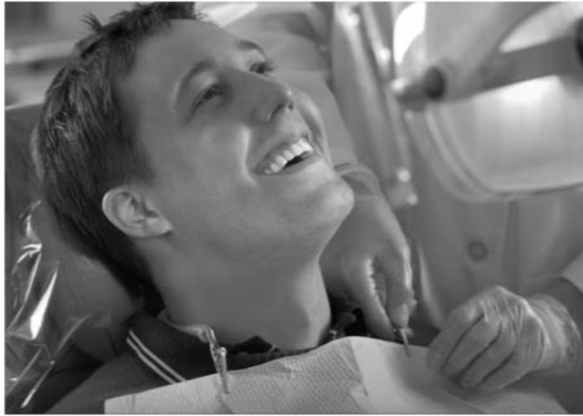
Security: In accordance with the security standards of HIPAA, *PEBB* shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the *Plan*;

(b) Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;

(c) Ensure that any agent or subcontractor to whom *PEBB* provides PHI agrees to implement appropriate security measures to protect such information; and

(d) Report to the *Plan* any successful security incident regarding PHI of which *PEBB* becomes aware.



THE ODS COMPANIES

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

MEMBER INQUIRIES

Portland: 503-265-5680
Toll-Free: 1-800-452-1058
TDD/TTY: 1-800-433-6313
(for the hearing and speech impaired)

Spanish Dental Customer Service
(Servicio al Cliente Area Dental)

Portland: 503-265-2963
Toll-Free: 1-877-299-9063
(llamado gratis)

DENTAL OFFICE INQUIRIES

Portland: 503-243-4494
Toll-Free: 1-800-452-1058

Member handbooks and other services are available at **www.odscompanies.com.**
Administrated by Oregon Dental Service.