CIS Benefits

Dental Option III

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

Insurance products provided by Oregon Dental Service.

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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	1-877-277-7280
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.

Welcome Using Your Program

Welcome to Oregon Dental Service (ODS). Created in 1955, ODS was the first company in America to provide prepaid dental insurance. Today we are Oregon's largest, covering over 500,000 people from more than 1,400 groups.

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

When you need dental care you may use any dental provider. However, **there are differences in reimbursement by ODS for Participating Dentists and Non-participating Dental Providers.** An example is provided on page 26. While an eligible person may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

During your first appointment, tell your dental provider that you have dental benefits through ODS. You will need to provide your subscriber identification number and ODS Group number to the dentist. These numbers are located on your I.D. card.

For expensive treatment plans, ODS provides a predetermination service. Your dentist may submit a predetermination request to get an estimate of what your insurance would pay. The predetermination will be processed according to your plan's current contract and returned to your dental provider. You and your dental provider should review the information before beginning treatment.

If you have questions about your plan, contact ODS' Customer Service Department in Portland at 503-265-5680 or toll-free at 1-877-277-7280, TDD 1-800-433-6313.

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.

Please note: This member handbook is a description of your dental care program. All plan provisions are governed by the Trust's Policy with ODS. This member handbook may not contain every plan provision. All provisions or terms of the Policy not described in this member handbook still apply.

Summary Plan Description

1. **Plan Name:**
   City County Insurance Services (CIS)

2. **Plan Sponsor:**
   City County Insurance Services
   1212 Court Street NE
   Salem, Oregon 97301
   (503) 763-3820

3. **Employer Identification Number:** 93-0895340

4. **Agent for Legal Process:** The Plan Sponsor named above.

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

6. **Plan Year:** August 1st through July 31st**.**

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

8. **Funding Medium and Type of Plan Administration**: This Plan is fully insured. Benefits are provided under a group insurance contract entered into between City County Insurance Services and Oregon Dental Service. Claims for benefits are sent to ODS. ODS, not City County Insurance Services, is responsible for paying claims.

   The Plan is funded by Participating Employer and/or employee contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is determined by the Trust and/or Participating Employer. (See Definition Section beginning on page 3 for definitions of Participating Employer and Trust).

9. **Provider of Benefits**: Benefits are provided in accordance with a Policy of Insurance between Oregon Dental Service and City County Insurance Services.

10. **Named Fiduciary**: City County Insurance Services.

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.

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

Co-payment means the relative percentages to be paid by the eligible person.

Covered Employee means an Eligible Employee for whom the Trust or Participating Employer has made contributions to provide dental benefits.

Covered Employment means employment for which a Participating 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 Eligible Employee's or dependent's eligibility for benefits becomes effective under the terms of this Policy.

Eligible Dependent means any of the dependents of an Eligible Employee who are eligible for benefits in accordance with the conditions of eligibility outlined in this Policy.

Eligible Employee refers to any individual who:

- is a permanent employee of a Participating Employer;
- works for a Participating Employer on a regularly scheduled basis working the minimal number of hours per week as determined by the Participating Employer;
- satisfies any Eligibility Waiting Period; and
- applies to and is accepted by ODS to be included in this Policy.

Eligible Person means any Eligible 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 Eligible Employee, dependent of the Eligible 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 employment or membership with the Participating Employer that a prospective Enrollee must complete before coverage begins.

Group Health Plan means any plan, fund or program established and maintained by a Participating 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 Payment Limit means the amount payable by the program for covered services received each calendar year, or portion thereof, for each eligible patient.

Maximum Plan Allowance

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.*

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.

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.

Participating Employer refers to an individual employer that:

- is considered a member company of the Trust;
- is considered a member in good standing; and
- is actively engaged in business which employs employees who are enrolled according to the requirements of the Trust Policy.

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).

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 City County Insurance Services including the application of the Trust 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 Trust for whose members or employees of its Participating Employers 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 commencing on the effective date and each 12-month period thereafter.

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.

The term "**Trust**" refers to the City County Insurance Services, a Trust organized under the laws of the state of Oregon for the purpose of representing and serving the interests of its Participating Employers who employ a combined minimum of Eligible Employees who are enrolled according to the requirements of the Trust Policy.

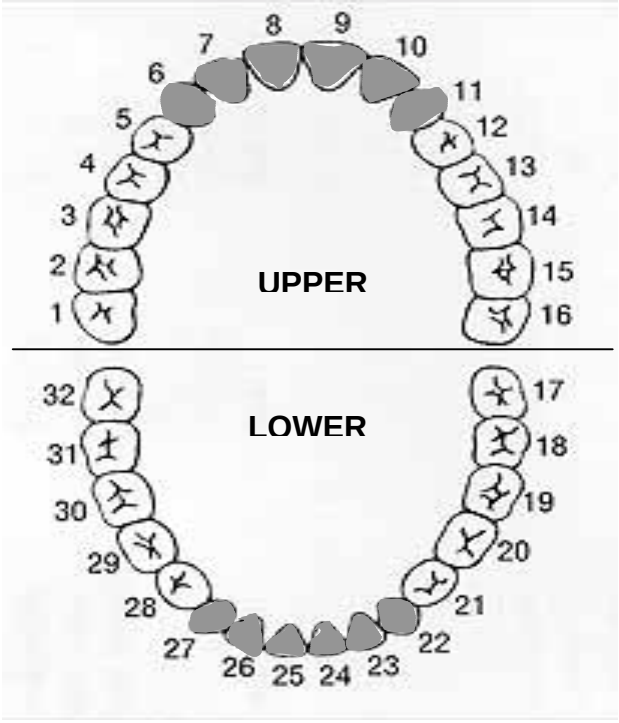
Veneer (chairside and laboratory) is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration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

ViziLite is a non-excisional soft tissue screening to detect oral cellular abnormalities.

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

Tooth Chart – The Permanent Arch

RIGHT



LEFT

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

This section describes who is eligible to enroll under the Plan. Please be aware that the date you become eligible may be different than the date insurance begins. See "When Insurance Begins" for more specific information. This is located in the "Enrollment" section beginning on page 14.

EMPLOYEES

You are eligible to enroll in the Plan if you work at least the minimum number of hours a week on a regular basis for the Participating Employer providing this coverage and you have satisfied any required waiting period. You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993.

DEPENDENTS

If you are married, your legal spouse is eligible for insurance. Your domestic partner is eligible for coverage if he or she meets the eligibility criteria on the Domestic Partner Affidavit provided by your employer. Your unmarried dependent children are eligible until their 23rd birthday. (See Loss of Eligibility By Dependent on page 15 for the date coverage will end.) Children eligible due to a court or administrative order are also subject to the Plan's child age limit.

Please Note:
All employers offer same gender only coverage. Check with your employer's group administrator to determine if opposite gender coverage is also available.

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

- Your natural child;
- Your spouse's or domestic partner's child or adopted child;
- Children placed for adoption with you;
- A newborn child of a covered dependent for the first 31 days of the newborn's life; and
- Children related to you by blood or marriage for whom you are the legal guardian. You will need to provide a court order showing legal guardianship or adoption paperwork when applicable.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for insurance even though he or she is over 23 years old. To be eligible, the child must be unmarried and principally dependent on you for support. The incapacity must have arisen before the child's 23rd birthday. You must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 23rd birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

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

Qualified Medical Child Support Order (QMCSO)

This Plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The effective date of coverage for a child added to the Plan under a QMCSO is the date specified in the court order, or if none, the date of the court order.

NEW DEPENDENTS

If you marry while you are insured under this Plan, your spouse and his or her children are eligible to enroll as of the date of the marriage. A complete and signed application must be submitted within 31 days of the date of the marriage. (See "When Insurance Begins.") All dependents must meet eligibility requirements.

Your domestic partner is eligible if he or she meets the criteria on the Affidavit of Domestic Partnership supplied by your employer. The domestic partner and his or her dependents are eligible to enroll within 31 days of when you and your partner have signed the affidavit. A complete and signed application must be submitted within 31 days of the date on the affidavit.

Your newborn child or your covered dependent's newborn child will automatically be insured for 31 days after birth. To continue insurance, the insured employee must submit a complete and signed application within those 31 days listing the new child as a dependent. If we do not receive the application, insurance for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

Adopted children are automatically insured for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be insured for the first 31 days from the date of placement. To extend insurance beyond the first 31 days, the insured employee must submit a complete and signed application along with the placement or adoption paperwork within those 31 days listing the child as a dependent.

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

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children.

Enrollment

This section explains how to enroll under the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want insured within 31 days of when you become eligible to apply for insurance. Employees are eligible to apply within 31 days of the date of hire. File the application with your Participating Employer.

You must notify your Participating Employer whenever you change your address.

SPECIAL ENROLLMENT

A. Loss of Other Coverage

If you decline coverage for yourself or your dependent(s) when initially eligible because of other dental coverage, you may enroll yourself or your dependent(s) in this Plan outside of the open enrollment period, but only if you satisfy the following criteria:

- You or your dependent(s) were covered under a group dental plan or had dental insurance coverage at the time coverage was previously offered to you;
- You stated in writing at such time that coverage under a group dental plan or dental insurance coverage was the reason enrollment was declined;
- Previous coverage for you or your dependent(s) ended;
- You request such enrollment not later than 31 days after the previous coverage ended.

The following individuals may enroll during the special enrollment period:

- You, the current employee, who lose other coverage;
- Your enrolled dependent who loses coverage under the other plan;
- You, the current employee, and your dependent if neither is enrolled under the Plan, and either loses coverage under the other plan.

To enroll yourself or your dependent you will need to submit a complete and signed application.

B. Enrolling New Dependents

You may obtain insurance for newly acquired or newly eligible dependents by submitting a complete and signed application within 31 days of their eligibility. To continue insurance for newborn children, you must submit a complete and signed dependent application before the child is 31 days old. To continue insurance for an adopted child or a child placed for adoption, you must submit a complete and signed dependent application within 31 days of adoption or placement.

You must notify us if family members are added or dropped from coverage, even if it does not affect your premium.

To enroll your new dependent you will need to submit a complete and signed application along with a domestic partnership affidavit, adoption or placement for adoption paperwork when applicable.

OPEN ENROLLMENT

If you do not enroll yourself and/or your eligible dependents within 31 days of first becoming eligible, you will be considered a "late enrollee" and must wait for the next Open Enrollment period to enroll. Open Enrollment occurs once a year at renewal.

WHEN INSURANCE BEGINS

Insurance coverage begins for you and any enrolled dependents on the first day of the month following the waiting period as determined by your Participating Employer.

When a new dependent is due to marriage, coverage begins on the date of marriage. The new spouse must be enrolled within 31 days of the date of the marriage.

For new dependents as a result of a domestic partnership, coverage begins the first day of the month following the date the application was signed.

When the new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage is effective on the date specified by the court order.

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

If you apply for insurance as a late enrollee, insurance will begin for you and/or your dependents on the date we specify with the acceptance of your application. All other Plan provisions will apply.

WHEN INSURANCE ENDS

A. Termination By Insured Employee

You may terminate your insurance, or insurance for any insured dependent, by giving us written notice through the Trust. Insurance will end on the last day of the month through which premiums are paid. If you terminate your own insurance, insurance for your dependents also ends at the same time.

B. Death

If you die, insurance for your insured dependents ends on the last day of the month in which your death occurs. Note that your insured dependents may extend their insurance for up to 3 years if the requirements for continuation of coverage are met (see page 35 for details). The Trust must notify us of any continuation of coverage, and appropriate premiums must be paid along with the Participating Employer's regular monthly payment.

C. Loss of Eligibility

If your employment terminates, your insurance will end for you and all insured dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 31).

D. Loss Of Eligibility By Dependent

A covered child will lose eligibility when he or she marries, reaches age 23 is no longer dependent on the Eligible Employee, or when the Eligible Employee is no longer legally required to provide insurance for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 31).

Insurance ends for an insured spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under this Plan (see page 31).

Insurance ends for a domestic partner on the last day of the month in which the domestic partnership ends.

E. 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.

F. Coverage for Spouses Aged 55 Years or Older

The following is applicable to policies issued in Oregon to Participating 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, the 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 section (see page 31 if he or she does not follow the election procedures as listed below.

In order to be eligible for continued coverage under this section, 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 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 under this section.

If the Plan Administrator fails to notify the 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 that would have been charged if the spouse was an Individual under this Plan plus the premium for coverage of dependent children, if any. The premium rate will include a 2% add-on to cover administrative expenses. 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 until the earliest of:

- The date the spouse becomes covered under any other group health plan;
- The date the spouse becomes entitled to benefits under Medicare;
- The last day of the month for which premiums were paid to us if coverage terminates due to non-payment of premiums; or
- The date the Plan terminates or the date the Trust or the Participating Employer terminates participation under this Plan.

Important Note: The following sections on Family and Medical Leave, Leave of Absence, and Uniformed Services Employment and Reemployment Rights Act (USERRA) may apply to you. Please check with your Participating Employer's benefits manager to find out whether you qualify for this coverage.

G. Family and Medical Leave

If your Participating Employer grants you a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply:

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave.
- If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to reenroll under the Plan on the date you return from leave. To reenroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the contract will resume at the time of reenrollment as if there had been no lapse in coverage. You will not have to re-serve any group eligibility-waiting period under the Plan.
- Your rights under FMLA will be governed by that statute and its regulations.

H. Leave of Absence

If you are granted a non-FMLA leave of absence by your Participating Employer, you may continue coverage for up to three months. Premiums must be paid through the Participating Employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by your Participating Employer at your request during which you are still considered to be employed and are carried on the employment records of the Participating Employer. A leave can be granted for any reason acceptable to the Participating Employer, including disability and maternity.

I. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. However, if you request to continue coverage under USERRA on or after December 10, 2004, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if you pay any required contributions toward the cost of the coverage during the leave. Employees who request this benefit prior to December 10, 2004, are eligible for up to 18 months of continued coverage or the period of uniformed service leave, whichever is shortest. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the Participating Employer if you are released under honorable conditions, but only if you return to active employment:

- On the first full business day following completion of your military service for a leave of 30 days or less;
- Within 14 days of completing your military service for a leave of 31 to 180 days; or
- Within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. There will be no additional eligibility waiting period and the pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your Participating Employer).

J. Other

See "Continuation of Coverage" section starting on page 31.

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 24 for exclusions.

Deductible: None

Maximum Payment limit: $1,500.00
Per eligible patient per calendar year, or portion thereof
All covered services (Class I, II, III) apply to Maximum Payment Limit

I. Class I: 70% is provided toward covered Class I services in the first calendar year an individual is eligible

Payment increases by 10% each successive calendar year. To qualify for this 10% increase, the individual must visit the dentist at least once during the calendar year. Class I services will be covered at **100%** at the end of three calendar years, assuming at least one visit to the dentist each of these years.

If in any calendar year the individual fails to receive covered dental services, the percentage for Class I services will remain at the same level. For each succeeding year the individual fails to receive covered dental services, the percentage for Class I services will decrease 10%, but it will never be reduced below 70%.

A. Diagnostic

Periodic (routine) or comprehensive examinations or consultations;
Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:

1. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
2. Only the following x-rays are covered by the plan: complete series or panoramic, periapical, occlusal, and bitewing.
3. ViziLite is covered once in any six (6) month period.

B. Preventive

Prophylaxis (Cleanings);
Topical application of fluoride;
Sealants.

Preventive Limitations:

1. Topical application of fluoride is covered for persons age 22 and younger.
2. Sealant benefits are limited to all surfaces on posterior, permanent teeth age 17 and under.

II. Class II: 70% is provided toward covered Class II services the first calendar year an individual is eligible

Payment increases by 10% each successive calendar year. To qualify for this 10% increase, the individual must visit the dentist at least once during the calendar year. Class II services will be covered at **100%** at the end of three calendar years, assuming at least one visit to the dentist each of these years.

If in any calendar year the individual fails to receive covered dental services, the percentage for Class II services will remain at the same level. For each succeeding year the individual fails to receive covered dental services, the percentage for Class II services will decrease 10%, but payment will never be reduced below 70%.

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 Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
5. A separate charge for general anesthesia and/or IV sedation is not covered when in conjunction with non-surgical procedures.

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);
Alveoloplasty.

Oral Surgery Limitations:

1. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered complex surgeries.
2. 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 6 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

Nonsurgical services of the connective tissues around and supporting the teeth.
Surgical periodontal exams, gingival curettage, gingivectomy, osseous surgery including flap entry and closure, mucogingivoplastic surgery, and management of acute infection and oral lesions related to the tooth structure.

E. Prosthodontic

Space maintainers to preserve the space between teeth caused by premature loss of a primary tooth;
Repair or relines of dentures and bridges.

Prosthodontic Limitations:

1. Space maintainers are a benefit when used to preserve the space between teeth because of premature loss of a primary tooth. The primary teeth are the first set of teeth, sometimes known as baby teeth. Space maintainers for missing permanent teeth or used in orthodontics to create a space between the teeth are not covered.
2. *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.

F. Palliative Emergency Treatment

Emergency treatment that is primarily for relief, not cure.

III. Class III: 70% is provided toward covered Class III services in the first calendar year an individual is eligible

Payment increases by 10% each successive calendar year. To qualify for this 10% increase, the individual must visit the dentist at least once during the calendar year. Class III services will be covered at **100%** at the end of three calendar years, assuming at least one visit to the dentist each of these years.

If in any calendar year the individual fails to receive covered dental services, the percentage for Class III services will remain at the same level. For each succeeding year the individual fails to receive covered dental services, the percentage for Class III services will decrease 10%, but it will never be reduced below 70%.

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 Class II 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;
Tissue Conditioning;
Bruxism splints and nightguards. (Appliances to reduce or prevent pain or damage from grinding of the teeth);
Dental Implants.

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:* 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. 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.

V. Non-Participating Dental Providers

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.

Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.

2. 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.

3. 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.
    - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, are excluded.

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), are excluded.

6. Services or supplies for periodontal splinting.

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

8. Gnathologic recordings or similar procedures are excluded.

9. Dental services started prior to the date the individual became eligible for such services under the Policy are excluded.

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 are excluded.

12. Charges for missed or broken appointments are excluded.

13. Experimental procedures or supplies are excluded.

14. Orthodontic services (treatment of malalignment of teeth and/or jaws) are excluded.

15. This Plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III 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 Trust or the Participating Employer transfers the Plan to another carrier.

16. This Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered complex oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.

17. Plaque control and oral hygiene or dietary instruction are not covered.

18. Claims submitted more than 15 months after the date of service are not covered.

19. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.

20. Services performed on the tongue, lip or cheeks are not covered.

21. Taxes.

22. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.

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

Coordination of Benefits (COB) occurs when you have healthcare 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 coverages, including Plan coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including 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;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits that exceeds $100 a day.

Each contract or other arrangement for coverage described above is a separate Plan.

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

For definition of **Claim Period** see Definitions Section, paragraph entitled "Claim determination period".

An **Allowable Expense** means any expense which is covered by at least one Plan during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the cash value of the service during a Claim Period will also be considered an Allowable Expense.

If a Plan benefit has a visit, day or dollars paid limitation and the limitation has been met, services in excess of the limitation will not be considered covered expenses for the purpose of this provision.

This Plan is the part of this Group contract that provides benefits for healthcare expenses.

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

The Secondary Plan (the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

WHICH PLAN PAYS FIRST?

When another Plan does not have a COB provision, that Plan is primary, and therefore determines and pays its benefits first. When another Plan does have a COB provision, the first of the following rules that applies will govern:

- **Non-dependent/Dependent.** If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will determine its benefits before a Plan which covers the person as a dependent.
- **Dependent Child/Parents Not Separated or Divorced.** If the claimant is a dependent child whose parents are not divorced or separated and the claimant is eligible for benefits under both parents' plans, then the Plan of the parent whose birthday falls earlier in the calendar year will determine its benefits before the Plan of the parent whose birthday falls later in that year. If both parents' birthdays are on the same day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.

- **Dependent Child/Separated or Divorced Parents.** If two or more plans cover the claimant as a dependent child of divorced or separated parents, then the following rules apply:

  - First the Plan of the parent with custody of the child, then the Plan of the spouse of the parent with custody of the child, and finally the Plan of the parent without custody.
  - However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person 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.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or non-dependent longer are determined before those of the plan which covered that person for the shorter time.

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

This COB provision will not apply to a claim when the Allowable Expense for a Claim Period is $50 or less. However, if additional expense is incurred during the Claim Period and the total Allowable Expense exceeds $50, then this COB provision will apply to the total amount of the claim.

CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Allowable Expense during the Claim Period.

COB AND PLAN LIMITS

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If this Plan pays more for an Allowable Expense than is required by this provision, the excess payment may be recovered from:

- The claimant;
- Any person to whom the payment was made; or
- Any insurance company, service plan or any other organization which should have made payment.

CORRECTION OF PAYMENTS

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them.

If we make payments that should have been made by another plan, we will have the right to recover them from the person to or for whom they were made, or from insurance companies or other organizations. The person involved must sign any documents that are necessary to enforce our rights under this provision.

Continuation of Coverage

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 Participating Employer's group dental plan. You may enroll in this Plan regardless of any other continuation coverage that may be available through the Trust or your Participating Employer. Information regarding this program will be sent to you should you lose coverage under your current employer plan.

CONTINUATION COVERAGE (COBRA)

EXPLANATION OF BENEFIT

IMPORTANT NOTICE

The following section on Continuation Coverage (COBRA) may apply to you. Please check with your Participating Employer's Human Resource Department to find out whether you qualify for this coverage. Both you and your spouse or domestic partner should read this notice carefully.

INTRODUCTION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law requiring certain employer-sponsored group health plans to offer continuation of coverage to qualified employees and their dependents. As a benefit to Plan members, ODS has agreed that COBRA will apply to all Participating Employers, regardless of size. This Plan will provide COBRA continuation coverage to all Eligible Employees subject to the following conditions:

- COBRA continuation coverage will be available only to Eligible Employees and their eligible dependents who are enrolled at the time of the qualifying event ("Qualified Beneficiaries").
- The Plan Administrator is responsible for providing all COBRA notices on a timely basis including the initial notice, the election notice, and notice of a qualifying event. Failure of the Plan Administrator to provide the required

COBRA notices, or to provide the required COBRA notices within the statutory time periods, to a Qualified Beneficiary will cause ODS' duty under this Policy to provide COBRA continuation coverage for such individual to end.

- The Plan Administrator must provide ODS with information about each Qualified Beneficiary electing continuation coverage. Such information shall include the name of the Participating Employer, the name and social security number of the Qualified Beneficiary, the qualifying event, and the date of the qualifying event. ODS will have no obligation to provide continuation coverage if this information is not timely and complete.

An Eligible Employee or the spouse/domestic partner 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/domestic partner or child may elect continuation coverage even if the Eligible 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. ODS 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 will include a 2% add-on to cover administrative expenses.

QUALIFYING EVENTS

A. Employee

As an Eligible Employee covered by this Plan, you may elect continuation coverage if you lose coverage for any one of the following three qualifying events:

(1) Termination of employment (other than termination for gross misconduct on your part);
(2) A reduction in hours; or
(3) If you are a retiree, your Participating Employer files for reorganization under Chapter 11 of the bankruptcy code.

B. Spouse or Domestic Partner

If you are the spouse/domestic partner of an Eligible Employee (or of a retiree for reason 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following five qualifying events:

(1) The death of your spouse/domestic partner;
(2) The termination of your spouse's/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse's/domestic partner's hours of employment with the Participating Employer;
(3) Divorce or legal separation from your spouse;
(4) Termination of domestic partnership;
(5) Your spouse/domestic partner becomes entitled to Medicare; or
(6) Your spouse's/domestic partner's Participating Employer files for Chapter 11 reorganization.

(Also, if an Eligible 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.)

C. Children

A dependent child of an Eligible Employee (or of a retiree for reason 6 below) covered by the Plan, has the right to continuation coverage if coverage is lost for **any** of the following six qualifying events:

(1) The death of the Eligible Employee;
(2) The termination of the Eligible Employee employment (for reasons other than gross misconduct) or reduction in an Eligible Employee hours of employment with the Participating Employer;
(3) Employee's divorce or legal separation or termination of domestic partnership;
(4) Eligible Employee becomes entitled (that is, covered) under Medicare;
(5) The dependent ceases to be a "dependent child" under the Plan; or
(6) The Eligible Employee's Participating Employer files for Chapter 11 reorganization.

OTHER COVERAGE

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

NOTICE REQUIREMENTS

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost), termination of domestic partnership occurs (domestic partner's coverage is lost), or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the Eligible Employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Trust and the Participating Employer for the plan; 2) the name and social security number of the Enrollee(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. When the Plan Administrator receives timely notice, you, your spouse, domestic partner, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives the notice. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. You, your spouse/domestic partner and dependent children will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, death of the Eligible Employee, or the Eligible Employee's becoming entitled to Medicare.

Election. You or your family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If continuation coverage (discussed below) is not elected, your, your spouse's/domestic partner's and your dependent's group health insurance coverage will end.

LENGTH OF CONTINUATION COVERAGE

If you choose continuation coverage, the Trust will provide the same coverage as is available to similarly situated employees or dependents under the Plan.

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

36-Month Continuation Period. In the case of losses of coverage due to an Eligible Employee's death, divorce or legal separation, termination of domestic partnership, a dependent child ceasing to be a dependent under the terms of the Plan, or the bankruptcy of the Participating Employer (applies to retiree plans only), coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the Eligible Employee's hours of employment, and the Eligible 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 Eligible 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 Eligible Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

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 an Eligible 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 Eligible 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 Eligible 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 Eligible 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 Eligible 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/domestic partners 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 Eligible 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 an Eligible Employee's, divorce or legal separation from the Eligible Employee, termination of domestic partnership, 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 an Eligible 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.

Note: Longer continuation coverage may be available under Oregon Law for an Eligible Employee's spouse age 55 and older who loses coverage due to the Eligible Employee's death, or due to legal separation or divorce. See page 16 for details.

NEWBORN OR ADOPTED CHILD

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

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, new domestic partners, and adopted children (or children placed for adoption) as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA participants can change plans at open enrollment, COBRA participants may also change plans at open enrollment.

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:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Participating Employer ceases to provide any group health plan for its Eligible Employees; or

- during a disability extension period (the disability extension is explained above), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

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

If you have any questions about COBRA, please contact the Plan Administrator. Please notify the Plan Administrator if you or your spouse/domestic partner have changed addresses.

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.

A. Second Election Period for Certain Trade-Displaced Individuals

Certain Eligible Employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Eligible 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.

B. 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.

C. 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 insurance, 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 claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A. Claim Submission

A claim must be submitted to ODS within 90 days after the date the expense was incurred. 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 absence of legal capacity, is a claim valid if submitted later than one year from the date submission is otherwise required.

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.

B. Explanation of Benefits (EOB)

Soon after you make a claim, we will report to you on the action we have taken by sending you a document called an Explanation of Benefits. We may pay claims, deny them, or apply the allowable expense toward satisfying the deductible. If we deny all or part of a claim, the reason for our 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.

C. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at (503) 265-5680 or toll-free at 1-877-277-7280 or write to our Dental Customer Service Department. We will respond to your inquiry within 30 days of receipt. You can also check the status of your claim on our website at **www.odscompanies.com**.

APPEALS

A. 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 in 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.

B. 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.

C. 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.

D. 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 1-877-277-7280 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.

E. 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 your 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 ODS. Here are descriptions of the situations that may arise.

A. Coordination of Benefits (COB)

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

B. Third-Party Liability

An individual covered by us 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 us. 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 we make an advance payment of Benefits, as described below, we are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by us 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/Insurance, as a service to you, we will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor our rights of subrogation as discussed below, and, if requested by us, to reimburse us 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/Insurance, the member agrees that we 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 us, including a dependent of a Member/Insured. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or dental/medical expenses of such individual.

2. "Benefits" means any amount paid by us, or submitted to us 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 dental/medical expenses from us, 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, we are 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/Insurance, we 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 our own name, or in the name of the member. We are entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan/Insurance.

Right of Recovery

In addition to our subrogation rights, we may, at our sole discretion and option, ask that the Covered Individual, and his or her attorney, if any, protect our 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 us, but only for the amount of Benefits we paid for that illness or injury.

2. We are entitled to receive the amount of Benefits we have 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, we are entitled to receive the amount

of Benefits we have 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 us, 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 we 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 us, 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. Our 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 us, 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/Insurance and will not be paid by us.

If a claim for health care expenses arising out of a motor vehicle accident is filed with us, and if motor vehicle insurance has not yet paid, then we 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, we, at our sole discretion and option, are 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 our rights to obtain reimbursement, or to exercise our 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 agree that we may do one or more of the following, at our discretion:

a. If the Covered Individual seeks payment by us 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 us 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, we require that any Covered Individual seeking payment of Benefits by us, 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 our 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 our rights;
    ii. Provide any information to us relevant to the application of the provisions of this Section, including dental/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 our rights to be reimbursed from Third Party recoveries.

e. By accepting the payment of benefits by us, 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 our 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 us whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by us.

i. If the Covered Individual continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we 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 have been exhausted.

j. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have 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 dental/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 dental/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 dental/medical coverage under more than one Plan or dental/medical 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 that we use 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

ODS will provide notification of material reductions in covered services or benefits to the Trust 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 ODS. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. We use your information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For more complete detail about how ODS uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on our website at www.odscompanies.com or by calling ODS at 503-243-4492.

TRANSFER OF BENEFITS

Only you and your insured 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 us.

RECOVERY OF BENEFITS PAID BY MISTAKE

If we make a payment for you or an insured 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 insured dependent even if the payment was not made on that person's behalf.

CONTRACT PROVISIONS

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

WARRANTIES

All statements made by the Trust, Participating Employers, or an insured person, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting insurance will avoid the insurance or reduce benefits unless contained in a written form and signed by the Trust, Participating Employers or the insured person, a copy of which has been given to the Trust, Participating Employers 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 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

Under state law, providers contracting with ODS to provide services to insured individuals agree to look only to ODS for payment of the part of the expense which is covered by the Plan and may not bill the insured individual in the event ODS fails to pay the provider for whatever reason. The provider may bill the insured for applicable co-payments and deductibles or non-covered expenses except as may be restricted in the provider contract.

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 a Participating Dentist's 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 a 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.

THE TRUST IS THE AGENT

The Trust is your and your enrolled dependents' agent for all purposes under this contract. The Trust is not the agent of Oregon Dental Service.

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 us 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.

THE ODS COMPANIES

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

MEMBER INQUIRIES

Portland: 503-265-5680
Toll-Free: 1-877-277-7280
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