CIS Trust

Delta Dental Premier Plan

Dental Plan III with Ortho

Effective Date January 1, 2016

TABLE OF CONTENTS

SECTION 1. WELCOME

This handbook describes the main features of CIS Trust's (CIS) dental plan (the "Plan"), but does not waive any of the conditions of the Plan as set out in the Plan Document.

The Plan is self-funded by CIS and has contracted with Delta Dental to provide claims and other administrative services. Delta Dental is part of the Moda Health organization.

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

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

This handbook may be changed or replaced at any time, by the Group, without the consent of any member. The most current handbook is available on myModa, accessed through the Moda Health website. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

1.1 MEMBER RESOURCES

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

Dental Customer Service Department
Portland 503-265-2965; Toll-free 888-217-2365;
En Español 503-265-2963; Llamado gratis 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Delta Dental
P.O. Box 40384
Portland, Oregon 97240

SECTION 2. USING THE PLAN

Delta Dental plans are easy to use and cost effective. If members choose a participating Delta Dental Premier dentist from the Delta Dental Premier Dental Directory (available on myModa by using “Find Care”), all of the paperwork takes place between Delta Dental and the dentist's office. More than 90% of all licensed dentists in Oregon are participating Delta Dental Premier dentists. For travelers and employees outside Oregon, Delta Dental’s national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

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

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

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

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

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

SECTION 3. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dentally Necessary means services that:

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

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

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

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

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

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

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

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

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

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 eligible persons or their dependents through insurance, reimbursement or otherwise. This dental benefit plan is a group health plan.

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

Implant Abutment is an attachment used to connect an implant and an implant supported prosthetic device.

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

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

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

Non-participating Dentist or dental provider means a licensed dental provider who has not agreed to the terms and conditions established by Delta Dental that participating Delta Dental Premier dentists have agreed to.

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

Participating Employer refers to an individual employer that:

a. is considered a member employer of the Group
b. is actively engaged in business which employs employees who are enrolled according to the requirements of this Plan

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

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

The **Plan** is the dental benefit plan sponsored and funded by CIS and your Participating Employer.

Plan Administrator means the Group.

Plan Sponsor means the Group.

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

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

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

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

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

SECTION 4. BENEFITS AND LIMITATIONS

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

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

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

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures. Limitations may apply to these services, and are noted below. See Section 5 for exclusions.

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

Deductible: None

Maximum payment limit: $1,500
Per member age 16 and over per year, or portion thereof
Covered Class I services do not apply toward maximum payment limit.

4.1 CLASS I:

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED.

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment never drops below 70%.

Class I services will be covered at **100%** at the end of 3 years, assuming at least one visit to the dentist each of these years.

4.1.1 Diagnostic

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

b. Diagnostic Limitations:

i. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
ii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
iii. Complete series x-rays or a panoramic film is covered once in any 5-year period*. Supplementary bitewing x-rays are covered once in any 12-month period*.

* This time period is calculated from the previous date of service.

4.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Sealants

b. Preventive Limitations:

i. Topical application of fluoride is covered once in any 6-month period* for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period* if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
ii. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars for members age 17 and under.

* This time period is calculated from the previous date of service.

4.2 CLASS II:

COVERED SERVICES PAID 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED.

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment never drops below 70%.

Class II services will be covered at **100%** at the end of 3 years, assuming at least one visit to the dentist each of these years.

4.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings on posterior teeth and composite fillings on anterior teeth for the treatment of decay.
ii. Stainless steel crowns

b. Restorative Limitations:

i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.2.1.
iv. Composite, resin, or similar (tooth colored) restorations in posterior teeth are considered optional services. If a composite or similar filling is used to restore posterior teeth, benefits are limited to the amount paid for an amalgam filling. The member is responsible for paying the difference.
v. Replacement of a stainless steel crown by the same dentist within 24 months of placement is not covered. The replacement is included in the charge for the original crown.

4.2.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical).
ii. Other minor surgical procedures.
iii. Alveoplasty.

b. Oral Surgery Limitations:

i. Surgery on larger lesions or malignant lesions is not considered minor surgery.

4.2.3 Endodontic

a. Endodontic Services:

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

b. Endodontic Limitations:

i. A separate charge for cultures is not covered.
ii. Pulp capping is considered to be included in the fee for the final restoration.
iii. 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.

4.2.4 Periodontic

a. Periodontic Services:

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

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.

ii. Full mouth debridement is limited to once in a 2-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

4.2.5 Anesthesia

a. Anesthesia Services:

General anesthesia or IV sedation is covered

i. In conjunction with covered surgical procedures performed in a dental office

ii. When necessary due to concurrent medical conditions

4.2.6 Prosthodontic

a. Prosthodontic Services:

i. Space maintainers to preserve the space between teeth caused by premature loss of a primary tooth;

ii. Repair or relines of dentures and bridges.

iii. Tissue conditioning

b. Prosthodontic Limitations:

i. 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.

ii. Denture adjustments and relines: A separate, additional charge for denture adjustments and relines done within 6 months after the initial placement is not covered.

4.2.7 Palliative Emergency Treatment

i. Emergency treatment that is primarily for relief, not cure.

4.3 CLASS III:

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED.

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment never drops below 70%.

Class III services will be covered at **100%** at the end of 3 years, assuming at least one visit to the dentist each of these years.

Note: Late enrollees are subject to a 12-month waiting period for Class III (Major) Services. A late enrollee is any person not enrolled when initially eligible.

4.3.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 4.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

4.3.2 Prosthodontic

a. Prosthodontic Services:

i. Bridges;
ii. Partial and complete dentures;
iii. Tissue Conditioning;
iv. Bruxism splints and nightguards. (Appliances to reduce or prevent pain or damage from grinding of the teeth);
v. Dental Implants and implant maintenance.

b. Prosthodontic Limitations:

i. A bridge or a full or partial denture will be covered once in a 7- year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. 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 retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
iv. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:

A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
B. An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. or

C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.
D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

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

4.3.3 Other

a. Other Services:
i. Athletic mouthguard

b. Other Limitations:
i. An athletic mouthguard is covered once per year for members age 15 and under and once every 2 years age 16 and over.

4.4 CLASS IV:
COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

Note: Late enrollees will be subject to a 12-month waiting period for Orthodontic Services. A late enrollee is any person not enrolled when initially eligible.

4.4.1 Orthodontia

a. Orthodontia Services:
i. Orthodontia for correcting malocclusioned teeth

b. Orthodontia Limitations:
i. Lifetime maximum of $1,000 per member. This maximum is not included in the annual maximum payment limit. Any deductible is waived.
ii. Payment for orthodontia will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the Plan. If treatment began before the member was eligible under the Plan, Delta Dental will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.
iii. Repair or replacement of an appliance furnished under the Plan is not covered

4.5 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will be responsible for the remainder of the dentist's fee.

4.6 NON-PARTICIPATING DENTISTS

The amounts payable for services of a non-participating dentist or dental care provider are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating dentist fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance.

SECTION 5. EXCLUSIONS

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

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

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

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

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service, except as stated in section 7.1.

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

Cosmetic Services

Duplication and Interpretation of X-rays

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

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

Gnathologic Recordings

Illegal Acts, Riot or Rebellion
Services and supplies for treatment of an injury or condition caused by or arising out of a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or arising directly from an illegal act.

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions or Training
Including plaque control and oral hygiene or dietary instruction.

Localized Delivery of Antimicrobial Agents

Missed Appointment Charge

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

Occlusal Adjustment and Non-Removable Splinting
Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. Such services include increasing vertical-dimension, equilibration and periodontal splinting.

Periodontal Charting

Periodontal Splinting

Precision Attachments

Services on Tongue, Lip, or Cheek

Service Related Conditions
Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war

Services Otherwise Available
Including those services or supplies:

a. Compensable under workers' compensation or employer's liability laws;
b. Provided by any city, county, state or federal law, except for Medicaid coverage; or
c. Provided, without cost to the member, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. Provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party (see section 7.3.2).

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ).

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

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

SECTION 6. ELIGIBILITY AND ENROLLMENT

The eligibility guidelines and enrollment requirements for the CIS Benefits Program are set forth in the Benefits Rules and the Benefits Enrollment Guide. Employees can access these documents on the CIS Benefits website at www.cisbenefits.org.

6.1 WORKERS' COMPENSATION CLAIM

If a subscriber is approved for a workers' compensation claim, he or she may continue active coverage for up to 6 months. At that time (assuming accrued leave has been exhausted), he or she will be offered continued coverage under the Continuation of Coverage (COBRA) provision.

6.2 RESCISSION

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud or intentional material misrepresentation by a member which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. The Plan will notify a member of the rescission 30 days prior to cancellation of coverage.

The Plan may also terminate a member's coverage retroactively for non-payment of premium. In the case of divorce or an ineligible dependent, the Plan will use the following guidelines to determine if termination should be retroactive.

a. If the employee notifies the employer of a divorce or a dependent becoming ineligible on an untimely basis, but the employer immediately takes action to update the enrollment, the Plan will terminate the coverage retroactively to the first of the month following the date of divorce or the date the dependent became ineligible.
b. If the employee notifies the employer of a divorce (timely or not) or of a dependent becoming ineligible, but the employer fails to update the enrollment, the coverage will not be terminated retroactively. It will be terminated the first of the month following a 30-day notice to the employee.

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 SUBMISSION AND PAYMENT OF CLAIMS

7.1.1 Claim Submission

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

7.1.2 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 8.1.1.

7.1.3 Claim Inquiries

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

7.2 APPEALS

7.2.1 Definitions

For purposes of section 7.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Delta Dental, in the form of a letter or an Explanation of Benefits (EOB), of any of the following:

a. rescission of coverage;
b. denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan;
c. 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 pre-existing condition exclusion or utilization review; and
d. 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 practice for the prevention or treatment of disease or accidental injury.

Final Internal Adverse Benefit Determination is an adverse benefit determination that has been upheld by Delta Dental at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

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

Complaint means an expression of dissatisfaction about a specific problem a member has encountered or about a decision by Delta Dental or an agent acting on behalf of Delta Dental, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the Plan.

Post-service claim means any claim for a benefit under the Plan for care or services that have already been received by a member.

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

7.2.2 Time Limit for Submitting Appeals

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

7.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level of review and a second level appeal. Delta Dental's response time to an appeal is based on the nature of the claim as described below. If a member is not satisfied with the outcome of the second level appeal, and the complaint meets the specifications outlined in section 9.2.6, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless the Plan agrees otherwise.

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

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

7.2.4 First Level Appeals

Before filing an appeal, it may be possible to resolve an appeal with a phone call to Delta Dental Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Delta Dental Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. Delta Dental will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the initial determination.

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, Delta Dental will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

7.2.5 Second Level Appeal

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or rationale is used by Delta Dental in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before Delta Dental's determination is sent. Delta Dental will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to file a lawsuit and the right to request an external review.

7.2.6 External Review

After exhausting the appeal process described in sections 8.2.4 and 8.2.5, unless such requirement is waived by the Plan, members may request external review of an adverse benefit determination or final internal adverse benefit determination, which include denials of claims, adverse coverage determinations and rescission but do not include disputes about eligibility to participate in the Plan except for those related to rescissions. The request for external review must be in writing no more than four months after receipt of the adverse benefit determination or final internal adverse benefit determination.

Within 6 business days following receipt of a request, Delta Dental will send a written notice to the member if the request is incomplete or ineligible for external review. Otherwise, the independent review organization will provide a written notice of the final external review decision within 45 days after its receipt of the request. For claims involving urgent care, the independent review organization will expedite the review and provide notice within 72 hours after its receipt of the request. The decision of the independent review organization is binding, except to the extent other remedies are available to the member under state or federal law.

7.2.7 Additional Member Rights

Members may contact the Employee Benefits Security Administration at 866-444-3272 for questions about their appeal rights or for assistance.

7.2.8 Administrative & Eligibility Appeals to CIS

Administrative appeals relate to decisions made by the employer. Eligibility appeals relate to employees missing enrollment timelines. Members may appeal an administrative or eligibility decision by appealing to the CIS Benefits Director within 45 days of the date of denial. The appeal must be made in writing. The Benefits Director will make a determination and send a written response and explanation within 15 days. If the Member is dissatisfied with the

decision, he/she may make a written request for reconsideration to the Executive Director within 45 days of the Benefits Director's denial. The Executive Director may, at his or her discretion, consult with the Board of Trustees and will respond with a notification of status of the request for consideration within 15 days. A final determination response will be sent in writing not later than 30 days from the date the request is received by the Executive Director. The Executive Director's determination is final, and there are no further appeal rights.

7.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

7.3.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 8.

7.3.2 Third-Party Liability

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

The member agrees that the Plan has the rights described in section 8.3.2. The Plan may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. Delta Dental has discretion to interpret and construe these recovery and subrogation provisions.

7.3.2.1 Definitions:

For purposes of section 8.3.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

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

8.3.2.2 Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them.

The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

8.3.2.3 Right of Recovery

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

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

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

c. If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan, a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

f. In third party claims involving the use or operation of a motor vehicle, the Plan, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538, or under applicable state law.

8.3.2.5 Additional Provisions

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

a. The member shall cooperate with the Plan to protect its recovery rights, including by:

   i. Signing and delivering any documents the Plan reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 8.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.
   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing its third party recovery rights

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

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

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 8.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 8.3.2.

f. Section 8.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

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

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

SECTION 8. COORDINATION OF BENEFITS

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

8.1 DEFINITIONS

For purposes of Section 8, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

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

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

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in

accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are **not** allowable expenses:

a. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider;
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
d. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the group dental benefit plan that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group health plan providing dental benefits is separate from this Plan. The group health plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

8.2 HOW COB WORKS

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

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

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

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

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

8.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan which covers the member as a dependent.
b. **Dependent Child/Parents Married, under a Domestic Partnership, or Living Together.** If the member is a dependent child whose parents are married, have a domestic partner relationship, or are living together whether or not they have ever been married or filed for a formal domestic partnership, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or under a domestic partner relationship, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.

iii. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows: The plan covering the
   A. Custodial parent;
   B. Spouse or domestic partner of the custodial parent;
   C. Non-custodial parent;
   D. Spouse or domestic partner of the non-custodial parent.

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

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

f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

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

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

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

8.4 EFFECT ON THE BENEFITS OF THIS PLAN

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

SECTION 9. MISCELLANEOUS PROVISIONS

9.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

9.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

9.3 TRANSFER OF BENEFITS

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

9.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

9.5 CORRECTION OF PAYMENTS

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

9.6 CONTRACT PROVISIONS

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

9.7 WARRANTIES

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

9.8 LIMITATION OF LIABILITY

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

9.9 PROVIDER REIMBURSEMENTS

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

9.10 INDEPENDENT CONTRACTOR DISCLAIMER

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

9.11 No Waiver

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

9.12 Group is the Agent

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

9.13 Governing Law

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

9.14 Where any Legal Action Must be Filed

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

9.15 Time Limits for Filing a Lawsuit

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

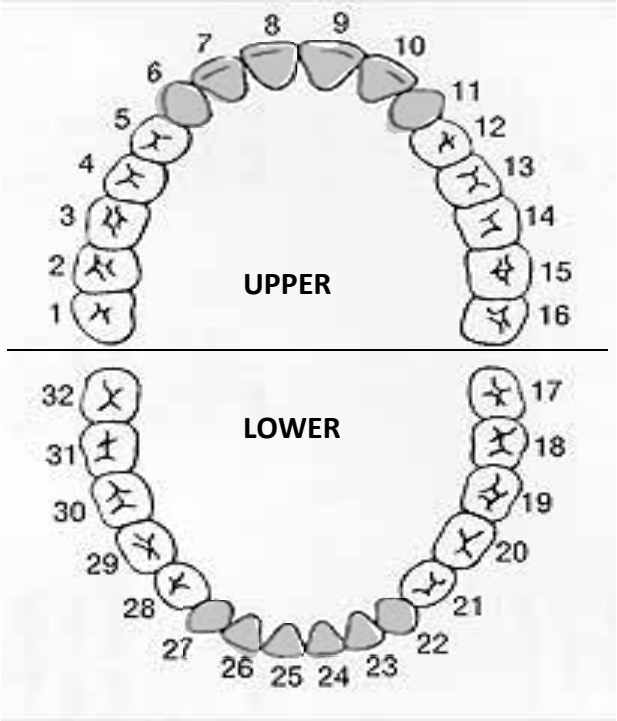
SECTION 10. CONTINUATION OF DENTAL COVERAGE

Continuation of Dental Coverage guidelines and requirements for the CIS Benefits Program are set forth in the Benefits Rules and the Benefits Enrollment & Eligibility Guide. Employees can access these documents on the CIS Benefits website at www.cisbenefits.org.

SECTION 11. TOOTH CHART

The Permanent Arch

R I G H T



L E F T

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)

For help, call us directly at 888-217-2365.
(En Español: 877-299-9063)

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