

Western States Health & Welfare
Trust Fund of the OPEIU

Dental Plans

WESTERN STATES HEALTH & WELFARE
TRUST FUND OF THE OPEIU

Dental Plan Booklet

Effective July 1, 2006

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GROUP BENEFITS INTRODUCTION

For Eligible Employees and Dependents
Provided Under the Group Agreement

Issued by

TRUSTEES OF THE
Western States Health & Welfare Trust Fund
of the OPEIU

This booklet contains a general description of dental benefits and is not a contract. Please refer to the Group Agreement (contract), which is on file with the Western States Health & Welfare Trust office (Administrative Office), for the complete details and benefit provisions of this program. In the event that any questions arise concerning benefits payable, the terms and provisions of the contract shall control.

Only the Administrative Office (the Plan Administrator) represents the Board of Trustees in administering the Plan and giving information relating to the amount of benefits, eligibility and other provisions of the contract. Statements by any other persons including your Employer or Local Union are not authorized by, and will not be binding on the Board of Trustees or the Trust.

The benefits described in this booklet, while intended to remain in effect indefinitely, cannot be guaranteed for any definite period of time. The Trustees reserve the right to make changes in this contract that they deem necessary, including benefit and eligibility changes, termination of all, or a portion of the coverage, or to require or to change monthly employee contributions.

If you would like further information or assistance, please call, write or email:

Western States Health & Welfare Trust Fund of the OPEIU
Administrative Office
c/o A & I Benefit Plan Administrators
1220 SW Morrison St, Suite 300
Portland, OR 97205-2222
www.westernstates.aibpa.com

Telephone: (503) 224-0048
Toll-free: 1-800-547-4457
Fax: (503) 228-0149

Sincerely,
The Trustees

SUMMARY PLAN DESCRIPTION

Plan Name and Administration

Western States Health & Welfare Trust Fund of the OPEIU is a health and welfare benefit plan which is jointly administered by six Trustees who are responsible for the administration of the Plan. Half of the Trustees represent the employers and half of them represent the union. The names and addresses of the Trustees are as follows:

Trustees Representing The Employer:

Terry Lansing
Bakery, Confectionery, Tobacco
Workers and Grainmillers
Local 114
7931 NE Halsey – Suite 205
Portland, OR 97213

Mr. David Williams
Northwest Natural Gas Co.
220 NW 2nd Ave.
Portland, Oregon 97209

Ms. Lea Anne Dolittle
Northwest Natural Gas Co.
220 NW 2nd Ave.
Portland, Oregon 97209

Trustees Representing the Union:

Mr. Mike Richards
O.P.E.I.U., Local No. 11
7931 N.E. Halsey - Suite 103
Portland, Oregon 97213

Marcia Williams
8630 NE Alberta
Portland, Oregon 97220

Rick Wilson
7931 NE Halsey, Suite 103
Portland, OR 97213

The Trustees employ A & I Benefit Plan Administrators (Plan Administrator) pursuant to a contract, to administer the Plan.

Eligibility for Participation and Benefits

The specific provisions relative to initial eligibility, continued eligibility and loss of eligibility are contained in the ELIGIBILITY section.

Funding

Benefits provided by the Western States Health & Welfare Trust Fund of the OPEIU are described in this booklet, except as noted below, are fully insured. Dental benefits are provided through Kaiser Permanente and Willamette Dental Group.

Dental Plans 10,11 and 12 are self-funded through the Trust.

Source of Funding: Contributions under Collective Bargaining Agreements

Employers contribute to Western States Health & Welfare Trust Fund of the OPEIU at a rate specified in a collective bargaining agreement. All contributions are made to the Trust Fund. Participants or beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan.

Claims and Appeal Procedures

Claims and appeals procedures for each dental plan are available from each insurer upon request without cost in a separate document. The claims and appeals procedures set forth in the MEMBER APPEALS AND GRIEVANCE PROCESS section applies to the Dental Plan 10, 11 and 12 only; but those claims and appeals procedures are similar to those of the insurers of other benefits. Correspondence relative to the claims and appeals procedure should be addressed to:

Western States Health & Welfare Trust Fund of the OPEIU
Administrative Office
c/o A & I Benefit Plan Administrators
1220 SW Morrison St, Suite 300
Portland, OR 97205-2222

Fiscal Year

The fiscal year of the Western States Health & Welfare Trust Fund of the OPEIU is March 1 through February 28.

Benefit Year and Contract Year

The benefit and contract year of the Western States Health & Welfare Trust Fund of the OPEIU is July 1, 2006 through December 31, 2007. The benefit and contract year of the Western States Health & Welfare Trust Fund of the OPEIU effective January 1, 2008 is January 1 through December 31.

Employer Identification Number and Plan Number

The employer identification number assigned by the Internal Revenue Service is 93-6028906. Plan No. 501.

Agent for Service of Process

The agent for service of process on Western States Health & Welfare Trust Fund of the OPEIU is:

Smith McKenzie Rothwell & Barlow, P.S.
500 Union Street, Suite 700
Seattle, WA 98101

Service of process may also be made upon a Trustee of the Plan.

Collective Bargaining Agreements

The Western States Health & Welfare Trust Fund of the OPEIU is the subject of collective bargaining agreements. Some provisions of the collective bargaining agreements relate to health and welfare benefits. The parties to the collective bargaining agreements are:

Office & Professional Employees International Union, Local No. 11

Individual Employers

Future of the Plan and Trust

The Trustees of Western States Health and Welfare Trust Fund of the OPEIU have established a Trust Fund. The Trust Fund is the entire estate of Western States Health and Welfare Trust Fund of the OPEIU as it may from time to time be constituted, including but not limited to policies of insurance, investments, and the income from any and all investments, employer contributions, and any and all other assets, property or money received by or managed by the Trustees for the uses and purposes of this Trust.

The Trust Fund is created, established, and maintained, and the Trustees agree to receive, hold, and administer the Trust Fund, for the purpose of providing benefits as now are, or hereafter may be, authorized or permitted by law for employees and their beneficiaries and in accordance with the provisions of this plan.

This Plan may be terminated should the Trust Fund, in the opinion of the Trustees, be inadequate to meet the payments due or that become due under the Plan; or should there be no individuals living who can qualify as employees or beneficiaries under the Plan; or should a termination be necessary as otherwise provided by law.

In the event of termination, the Trustees shall:

- Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;
- Arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;
- Apply the Trust Fund to pay any and all obligations of the Trust and distribute and apply its capital and surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Name and Address of Administrator and Request for Information and Documents

All requests for information or correspondence relative to coverage, benefits and interpretation of Western States Health & Welfare Trust Fund of the OPEIU should be addressed to Western States Health & Welfare Trust Fund of the OPEIU. In addition, all requests for documents should be in writing and addressed to:

Western States Health & Welfare Trust Fund of the OPEIU
Administrative Office
c/o A & I Benefit Plan Administrators
1220 SW Morrison St., Suite 300
Portland, OR 97205-2222

The Trustees may make a reasonable charge for any documents requested. The Plan Administrator will state the charge for specific documents on request, so you can find out the cost before ordering.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Western States Health and Welfare Trust Fund of the OPEIU, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request of the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue dental care coverage for yourself and your eligible dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You and your eligible dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this booklet.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your Plan when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition

exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and the interest of other Plan participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. You have the right to be represented by an attorney or any other representative of your choosing. If you are dissatisfied with the Plan's determination after you have exhausted the Plan's appeal process, you may file suit in state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance for the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining

documents from the Plan Administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW Washington, D.C. 20210. The Seattle regional office of the Pension and Welfare Benefits Administration office is located at:

MIDCOM Tower
1111 Third Avenue, Suite 860
Seattle, WA 98101-3212

Telephone Number: (206) 553-4244

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

If an Active Employee performs service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. An Active Employee may choose to freeze his/her eligibility status until the period of service ends, or continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniform Services" means the Armed Services (including the Coast Guard), the Army National Guard and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If an Active Employee (and his or her eligible dependents) is eligible for benefits as of the date of entry into Uniformed Services, and the Employee's absence is due to a uniformed services leave of 31 days or less, coverage will be continued at no cost to the Employee. The Employee will be credited with hours necessary to keep coverage in effect as if the Employee worked in covered employment with a contributing employer during the period of service.

If an Active Employee (and his or her eligible dependents) is eligible for benefits as of the date of entry into Uniformed Services, and the Employee's absence is due to uniformed services of 31 days or more, the Employee or eligible dependents may elect to continue coverage by self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A premium for continuation coverage under USERRA will be in an amount established by the Trust. The premium will be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

- 24 months beginning on the day that the uniformed service leave commences; or
- a period ending on the day after the active Employee fails to return to employment within the time allowed by USERRA

If an Employee does not elect to continue coverage, eligibility status will be frozen as of the date of entry into Uniformed Services. Eligibility for coverage for any eligible dependents will terminate at the end of the month in which the Employee entered into Uniformed Services.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders and enrolls Dependent children as directed by such orders. A Qualified Medical Child Support Order (QMCSO) with respect to this plan is an order which recognizes a Dependent child's right to receive health benefits for which an employee is eligible under the Plan. The Plan must enforce a QMCSO whether or not the employee or child is enrolled in the Plan.

When the Plan Administrator receives a medical child support order, the Plan Administrator shall promptly notify the employee and the child of the receipt of such order and provide them with the Plan's procedures for determining whether the order is qualified and within a reasonable period after receipt of such order, determine whether such order is qualified and notify the employee and child of such determination. A notice will also be sent to each attorney or representative named in the order or accompanying correspondence.

In general, a medical child support order will be qualified if it clearly specifies the name and last known address of the employee and child, gives a reasonable description of the coverage that must be provided to the child, specifies the period to which such order applies, provides the name of the plan to which the order applies and specifically states that the child must be covered by this Plan.

If the order is not qualified, the notice will give the specific reason for the decision. The party filing the order will be given an opportunity to correct the order or appeal the decision through the claims review procedures explained in this booklet. If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire Qualified Medical Child Support Order and any required self payments must be received prior to enrollment. Any child enrolled pursuant to an order will be subject to all provisions applicable to Dependent coverage under the Plan.

If a medical child support order requires coverage of a noncustodial child in which an “appropriately completed National Medical Support Notice” is issued, and the notice is deemed a “Qualified Medical Child Support Order” (as described above), the Plan Administrator within forty (40) business days of the date of the Notice shall:

1. Notify the state agency issuing the notice with respect to such child whether coverage of the child is available under the Plan and the effective date of the coverage; and
2. Provide the custodial parent a description of the coverage available and any forms or documents necessary to establish such coverage.

A notice is appropriately completed if it contains the name of the issuing agency, the name and mailing address of the employee and dependent child and identifies the underlying child support order.

Western States Health & Welfare Plan Of The OPEIU HIPAA Privacy Notice

The Board of Trustees of the Western States Health & Welfare Plan of the OPEIU hereby adopt the following Amendment to all benefit plans maintained by the Trust. This Amendment is intended to meet the requirements of 45 CFR 164.504(f) which requires plan documents of group health plans be amended in order to disclose protected health information to the Board of Trustees as Plan sponsor. The Amendment shall be construed in accordance with the applicable laws and regulations. If the terms and conditions of any plan conflict with this Amendment, the terms of this Amendment shall control.

1. Use and Disclosure of Protected Health Information by Trustees:

The Board of Trustees shall use and/or disclose Protected Health Information only to the extent necessary to perform the following Plan administrative functions, which are performed on behalf of the Plan: to conduct health care operations; in connection with claims appeals, judicial and administrative proceedings; when legally required for law enforcement purposes; to consider Plan amendments; to conduct Plan oversight activities, including determination of proper funding, levels of reserves and contributions needed; for specified government functions; and/or for payment or operations.

2. Disclosure of Protected Health Information to Trustees:

The Plan Administrator shall disclose Protected Health Information to the Board of Trustees only to the extent necessary to perform the Plan's administrative functions; which may include any of the functions listed above.

3. Trustee Certification:

The Plan Administrator agrees that it will disclose Protected Health Information to the Board of Trustees only upon receipt of a certification that this Amendment has been adopted and the Board of Trustees, as Plan sponsor, agrees to abide by such conditions. The Board of Trustees agrees to the following:

a) Prohibition on Unauthorized Use or Disclosure of Protected Health Information:

The Board of Trustees, as Plan sponsor, and each Trustee individually, agrees to not use or disclose any Protected Health Information received from the Plan Administrator, except as permitted in this Amendment or required by law.

b) Subcontractors and Agents:

The Board of Trustees will require each of its subcontractors or agents to whom it may provide Protected Health Information to agree to written contractual provisions that impose at least the same obligations to protect the use and disclosure of Protected Health

Information as are imposed on the Board of Trustees.

- c) Permitted Purposes:
The Board of Trustees, collectively and as individuals, will not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any unrelated benefit or other employee benefit plan.
- d) Reporting:
The Board of Trustees will, collectively or individually, report to the Plan Administrator's Privacy Official any known impermissible or improper use or disclosure of Protected Health Information not authorized by this Amendment of which it becomes aware.
- e) Disclosure to Government Agencies:
The Board of Trustees will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Plan Administrator and to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining this Plan's compliance with HIPAA.
- f) Return or Destruction of Health Information:
When the Protected Health Information is no longer needed for the purpose for which disclosure was made, the Board of Trustees will, if feasible, return to the Plan Administrator or destroy all Protected Health Information that the Board of Trustees, individually or collectively, received from or on behalf of the Plan Administrator. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Board of Trustees, individually and collectively, agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible. This provision shall be interpreted in accordance with the record retention requirements of ERISA and Section 164.530(j)(2) of the Privacy Rule.
- g) Minimum Necessary Requests:
The Board of Trustees will use its best efforts to request only the minimum necessary type and amount of Protected Health Information to carry out the functions for which the information is requested.

4. Trustee Certification As to Participant Rights:

The Board of Trustees also certifies it will observe the following in regards to Plan participants and their Protected Health Information.

- a) Access to Protected Health Information by Participants:
The Board of Trustees will make Protected Health Information available to the Plan Administrator to permit participants to inspect and copy their Protected Health Information contained in a designated record set.

- b) **Amendment of Protected Health Information:**
The Board of Trustees will make a participant's Protected Health Information available to the Plan Administrator to permit participants to amend or correct Protected Health Information contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate amendments provided by the Plan Administrator.
- c) **Accounting of Protected Health Information:**
The Board of Trustees will make a participant's Protected Health Information available to permit the Plan Administrator to provide an accounting of disclosures.

5. Adequate Separation:

The Board of Trustees represents that adequate separation exists between the Plan Administrator and the Board of Trustees so that Protected Health Information will be used only for Plan administration purposes. The following persons under the control of the Board of Trustees will have access to participants' Protected Health Information for the purposes set forth under number 1 above:

- a) Employees of the Trust with responsibility for claims administration; and
- b) Employees/independent contractors of the Trust with oversight responsibility for claims administration, plan design, claims management, accounting, and analysis.

6. Restriction to Access and Adequate Separation Certification:

The Board of Trustees certifies that the individuals and entities identified above are the only ones that will have access to and use of participants' Protected Health Information in regards to the uses and disclosure related to the Plan sponsor's function set forth in paragraph 1.

7. Effective Mechanism for Resolving Issues of Noncompliance:

The Board of Trustees certifies that any individual or entity described in paragraph 5 who suspects an improper use or disclosure of Protected Health Information may report the occurrence to the Plan Administrator's Privacy Official at the following address:

A & I Benefit Plan Administrators
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Telephone: (503) 224-0048
Toll-Free: 1-800-547-4457
Fax: (503) 228-0149

ELIGIBILITY

The annual open enrollment period is mid-October to mid-November every year effective 2007. This is the period of time when you have the option to change dental plans. Dental plan changes will be effective January 1 of the following calendar year.

Employee Eligibility

Eligibility is based upon contributions received on your behalf for hours worked for contributing employers under the jurisdiction of Western States Health & Welfare Trust Fund of the OPEIU.

The rules for initial and continuing coverage are identical; that is, any time you work sufficient hours in one month, you will receive a month of coverage in another month.

You and your dependents will become covered on the first day of the second month following a month in which you work the qualifying hours per your labor contract. The employer pays a contribution on your behalf (in the month following your work) on the basis of those qualifying hours.

For example:

First Month:	This is the work month in which you must work enough hours per the labor contract.
Second Month:	This is the month your employer sends the contribution to the Trust. This month is sometimes called the "lag month."
Third Month:	This is the month you and your eligible dependents are covered.

This is what it looks like on an ongoing basis:

Work Month:	Jan.	Feb.	Mar.	Apr.	May	Etc.
Lag Month:	Feb.	Mar.	Apr.	May	Jun.	
Coverage Month:	Mar.	Apr.	May	Jun.	Jul.	

Loss of Employee Eligibility

If you fail to work the qualifying hours in any month, your employer is not obligated to make a contribution on your behalf and you will lose

coverage at the end of the month following the month you failed to work sufficient hours.

For example: you worked steadily for many months and had continuous coverage, but failed to work enough hours in the month of March. Your prior work months would provide you with coverage through April 30th, but because no payment would be made to the Plan Administrator in April for March work, there would be no coverage for the month of May.

See the CONTINUATION OF COVERAGE (COBRA) section.

When Your Dependents Lose Eligibility

Coverage ends for an enrolled child on the last day of the monthly period in which the child is no longer eligible according to the terms of the Plan.

Waiver of Premium

If you suffer an accident or illness and your disability causes you to lose coverage (in a rolling 24-month period), you may be eligible for benefits for up to six months, at no cost to you, per a special Waiver of Premium provision of the Plan. It is your responsibility to notify the Plan Administrator of your disability and you will need to request that you be granted a disability waiver. In addition, you may make self-payments to extend your coverage, according to the CONTINUATION OF COVERAGE (COBRA) section of this benefits booklet.

This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act of 1993 requires certain employers to allow eligible employees up to 12 weeks of unpaid leave during a 12-month period.

The federal eligibility requirements do not require coverage for all participants in the Western States Health & Welfare Trust Fund of the OPEIU (Plan).

The Board of Trustees reviewed the application of the FMLA to the Plan's participants. The Board of Trustees determined that the Plan will provide more liberal benefits than required by FMLA to all employees in the Plan. An employee is eligible for these benefits if an employee satisfies all of the following requirements:

- is on unpaid leave because of FMLA or equivalent leave required by state law, or under the collective bargaining agreement.
- is taking the leave for:

- the care of the employee's child (birth, placement for adoption or foster care); or
 - the care of an immediate family member (spouse, child or parent) with a serious health condition; or
 - a serious health condition for which prevents the employee from working.
- worked at least 1,250 hours for the employer within the previous 12 months.

If you satisfy all three requirements, you will receive health benefits equivalent to that required by FMLA.

The Board of Trustees will constantly monitor its decisions. The results of the monitoring could require a change in the Board of Trustees' policy decisions.

Strike Or Lockout

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by the group, directly to the union or trust that represents you. And the union or trust must continue to pay the Plan Administrator the premiums on the Premium Due Date. Coverage cannot be continued if fewer than 75 percent of those normally enrolled continue coverage or if you otherwise lose eligibility under the Plan.

This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

ELIGIBILITY DEFINITIONS

Enrollee (also called Subscriber) means either the enrolled employee (also called employee) or the enrolled dependent.

Dependent means the following:

The enrolled employee's legal spouse or domestic partner, and the enrolled employee's/domestic partners unmarried children under 21 years of age (coverage ends at the end of the month of your child's 21st birthday) or if your child is a full-time student in an accredited school, 23 years of age who are dependent on the enrolled employee for support, and who are enrolled under the Plan.

The following are considered children:

- the enrolled employee's or domestic partners natural child;
- the enrolled employee's or domestic partners adopted child, a child placed for adoption with the enrolled employee or domestic partner, a stepchild living in the enrolled employee's home or a nonresident stepchild if there is a qualified medical child support order that requires the spouse to provide health insurance coverage; and
- children related to the enrolled employee or domestic partner by blood or marriage, which may include grandchildren if the natural mother or father are an eligible family dependent and enrolled in this plan or for whom the employee is the legal guardian (the enrolled employee will need to give us a court order showing legal guardianship).

The newborn child of an enrolled employee, of an enrolled employee's domestic partner, or of an enrolled dependent will be covered for 31 days after it is born. We must have notice of the birth and in the case of a newborn of a male dependent, proof of paternity. To continue the newborn's coverage beyond this 31-day period, the child must be eligible under the terms of the Plan and the enrolled employee must sign a new application within 60 days listing the child as a dependent. If this is not done, coverage for the child will lapse at the end of 31 days.

In addition, incapacitated children can remain enrolled past the age of 23. An incapacitated child is an unmarried child who is incapable of self-support because of a physical handicap or mental retardation. The incapacitating condition must have existed before the child's 23rd birthday. In order to obtain continued coverage for an incapacitated child, the enrolled employee must complete a special application and have it approved by us before the child's 23rd birthday.

Enrollees may obtain from the Plan Administrator, without charge, a copy of the procedures governing qualified medical child support order determinations.

Newly Acquired Dependents

If an enrolled employee marries while he or she is enrolled under the Plan, his or her spouse and the spouse's children become eligible to apply for coverage on the date of the marriage. Application for coverage must be made within 31 days after the date of marriage. If application is made within this time period, coverage shall become effective on the date of the marriage. If the application is not mailed within 31 days the new spouse may not enroll in this Plan until open enrollment. The new stepchildren must meet the eligibility requirements for all children in order to be enrolled.

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 after the date on which you and your partner have both signed the affidavit. A complete and signed application must be submitted within 31 days after the date on the affidavit.

An enrolled employee's or an enrolled female dependent's newborn child will automatically be enrolled for 31 days after it is born. To continue the newborn's coverage beyond this 31-day period, the child must be eligible under the terms of the Plan.

Adopted Children

A child will be enrolled as an enrolled employee's dependent child for 31 days after the date the child is placed with the enrolled employee or domestic partner for the purpose of adoption. "Placement" means the enrolled employee or domestic partner has assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

In order to continue this coverage beyond the first 31 days, the enrolled employee must sign a new application within the first 31 days listing the child as a dependent, along with proof of placement. If this is not done, coverage for the child will terminate at the end of the 31st day after placement.

Special Enrollment

An eligible individual will not be considered a late enrollee in the following situations:

- If you and/or your eligible dependents lose coverage under another group or individual health benefit plan due to:
 - the exhaustion of federal COBRA or Oregon state continuation;

- the loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours; or the employer contributions were terminated; or
- involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan, like Oregon Health Plan.

In all of the above situations, you and/or your eligible dependents become eligible for coverage under this Plan on the date the other coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid in time, or termination of coverage because of fraud.

- If you declined coverage when you were first eligible and you subsequently marry, you become eligible for coverage under this Plan on behalf of yourself, your spouse and any eligible dependent children on the date of marriage.
- If you declined coverage when you were first eligible and you subsequently acquire a new dependent child by birth, adoption, or placement for adoption, you become eligible for coverage under this Plan along with your eligible spouse and eligible dependent children including the newly acquired child on the date of the birth, adoption, or placement.
- If a spouse or domestic partner and/or dependent child for whom you declined coverage becomes eligible for coverage under this Plan on the date a court has issued an order for you to provide such coverage.
- If you and/or your eligible dependents enroll during an open enrollment period under the Plan, if any. Contact the Plan Administrator to find out if you have an open enrollment period.
- If you and/or your eligible dependents are employed by an employer who offers multiple health benefit plans and you and/or your eligible dependents enroll during an open enrollment period under the Plan, if any. Contact the Plan Administrator to find out if you have an open enrollment period.

CONTINUATION OF COVERAGE (COBRA)

Under certain circumstances, you and/or your enrolled dependents may have the right to continue health coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this Continuation of Coverage provision and COBRA, COBRA shall govern.

The enrolled employee has the right to elect continuation of coverage if he or she would otherwise lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

The enrolled employee's spouse has the right to choose continuation of coverage if he or she would otherwise lose coverage for any of the following reasons:

- the enrolled employee dies;
- termination of the enrolled employee's employment (for reasons other than gross misconduct) or reduction in the enrolled employee's hours of employment;
- dissolution of marriage or legal separation from the enrolled employee; or
- the enrolled employee becomes entitled to Medicare.

An enrolled dependent child has the right to continuation of coverage if coverage would otherwise be lost for any of the following reasons:

- the enrolled employee dies;
- termination of the enrolled employee's employment (for reasons other than gross misconduct) or reduction in the enrolled employee's hours of employment;
- dissolution of marriage or legal separation from the enrolled employee; or
- the enrolled employee becomes entitled to Medicare; or.
- the child loses eligibility as a dependent under the Plan.

A natural born child or a child placed for adoption with you who is properly enrolled under the terms of the Plan during the continuation period shall be considered a qualified beneficiary.

Notification Responsibilities

The enrolled employee or his or her enrolled dependent has the responsibility to inform the Plan Administrator in writing of a divorce, legal separation, second qualifying event, disability extension or a child losing dependent status within 60 days of the date of the event. Within 30 days of the qualifying event, the employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours or Medicare entitlement. The employee must notify the Plan of a determination that the employee is no longer disabled within 30 days of such determination.

Once Notification Is Given

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify the employee or his or her enrolled dependent that the employee or his or her enrolled dependent has the right to elect continuation coverage. Under this provision, the employee or his or her enrolled dependent has 60 days from the date coverage would otherwise be lost because of one of the events described previously or 60 days from the date of notification from the Plan Administrator, whichever is later, to elect continuation coverage. Failure to elect continuation coverage within that period will cause group health plan coverage to end as it normally would under the terms of the Agreement.

Available Coverage

The health coverage for continuation of coverage is required to be the same as that provided to similarly situated employees and their enrolled dependents.

Making Monthly Payments

The employee or his or her enrolled dependent is responsible for the full cost of continuation coverage. Premium for continuation coverage must be paid to the Plan Administrator on a timely basis within 30 days of the first of the month. The only exception is the premium payment for the period preceding the election which may be made up to 45 days from the date of election. Premium for those on continuation coverage must be submitted to the Plan Administrator each month on a timely basis in order to maintain continuation coverage.

Special COBRA Election Rules International Trade Act of 2002

If coverage is lost due to an international trade agreement an employee has a separate 60 day election period to elect COBRA continuation coverage.

How Long Continued Coverage Lasts

Coverage may be continued as follows:

- For termination of employment or reduction of hours, continuation may last for up to 18 months. However, there is one exception. It applies when a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of continuation coverage. In that situation, each qualified beneficiary may have up to a total of 29 months of continuation, but only if the Social Security Administration makes the determination within the first 18 months of that continuation period and the qualified beneficiary notifies the Plan Administrator both within that 18-month period and within 60 days of the determination. Thereafter, if there is a final determination of nondisability, the qualified beneficiary must so notify the Plan Administrator within 30 days. The extended continuation will end the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled.
- For death, dissolution of marriage, or the covered employee's legal separation, continuation may last for up to 36 months.

However, there is a special Oregon statute (applicable to insurance policies issued in Oregon to employers of 20 or more employees) that allows a spouse who is age 55 or over at the time coverage would otherwise end due to the death, dissolution of marriage, or legal separation to remain covered beyond 36 months until covered by another group health plan or until age 65, whichever happens first. Covered dependent children of the spouse may remain covered with the spouse beyond 36 months as long as they are otherwise eligible under the Plan.

- For an enrolled dependent child ceasing to be eligible as a dependent under the Plan, continuation may last for up to 36 months.
- If the covered employee becomes entitled to Medicare thereby causing a loss of coverage for covered dependents, continuation will last for up to 36 months.

Multiple Qualifying Events

- In the case of multiple qualifying events (a qualifying event followed by one or more qualifying events), a qualified beneficiary shall upon proper notice to the Plan Administrator of the succeeding qualifying event, continue for up to 36 months from the date the original continuation began. However, if an active enrolled employee with covered dependents becomes entitled to Medicare, the period of continuation for his or her covered

dependents for any subsequent qualifying event may be continued until the later of:

- 36 months from the date of Medicare entitlement; or
- the end of any other continuation period to which an enrollee is entitled.

Termination

Notwithstanding the previous statements, in all situations, continuation under this Plan will end for a person on the last day of the monthly premium payment period in which any of the following occurs, whichever happens first:

- premium for a person on continuation of coverage is not paid to the Plan Administrator on a timely basis;
- after electing continuation a person becomes covered under any other group plan. However, coverage under another plan will not cause continuation to end so long as the other plan excludes or limits coverage for a preexisting condition of a qualified beneficiary in accordance with federal law;
- after electing continuation of coverage a person becomes entitled to Medicare); or
- the applicable period of continuation of coverage ends.

In addition, continuation will end on the day the Plan terminates, or, if applicable, the day the employer withdraws from participation under the Plan. However, continuing coverage may still be available under the succeeding plan unless the employer no longer provides a group health plan for any of its employees.

MEMBER APPEALS AND GRIEVANCE PROCESS

The text in this section is contributed by the Board of Trustees for the Western States Health and Welfare Trust Fund of the OPEIU and applies only to Dental Plan 10, 11 and 12 sections of this book.

This section may be used as general guidelines for other covered benefits. Please consult your dental carrier for specific procedures.

I. Claim Denial

A. Processing of Claims

Claims that are properly filed will be processed in accordance with the following guidelines:

- (1) *Post-Service Health Claims* - A post-service claim is any properly filed claim for dental benefits that is not a pre-service claim as defined below except for an urgent care claim. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan Administrator determines an extension of time for making the determination is necessary due to matters beyond the control of the Plan Administrator, and notifies the employee or beneficiary (hereafter "claimant") within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

- (2) *Pre-Service Claims* - A pre-service claim is a properly filed dental claim which must be preauthorized to receive full benefits from the Plan. Pre-service claims means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan Administrator determines an extension of time for making the determination is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

- (3) *Urgent Care Claims* – An “urgent care claim” is a claim with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject matter of the claim. If the insured needs dental care for a condition that could seriously jeopardize his/her life, there is no need to contact the Plan Administrator for approval. The Plan does not require precertification of Urgent Care services. An urgent care claim will be processed and adjudicated as a post service claim.
- (4) *Concurrent Claims* - A “Concurrent Claim” arises when the Plan Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan Administrator determines that the course of treatment should be reduced or terminated, or (b) the insured requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the insured to obtain approval of a dental service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The insured simply follows the Plan's Administrator's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post Service Claim.

B. Notification of Claim Denial

If a dental claim is denied or partly denied, the claimant will be notified in writing and given an opportunity for review. The written denial will give:

- (1) The specific reasons for the denial.
- (2) Specific reference to pertinent Plan provisions on which the denial is based.

- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (4) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.
- (5) If the denial is based on dental necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's dental circumstances, or a statement that such an explanation will be provided free of charge upon request.
- (6) An explanation of the Plan's claim review procedure, including a statement of the claimant's right to bring a civil action under ERISA § 502(a).

II. Appeal To Board of Trustees

A. Notification of Appeal

Any claimant who applies for benefits and is ruled ineligible by the Trustees (or by the Plan Administrator acting for the Trustees), or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees, will have the right to appeal to and request review of the matter by the Board of Trustees, provided that he makes such a request, in writing, within 180 days after the Trustee's action or within 180 days after receipt of the notification or decision.

The appeal will be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees, which has been allocated the authority for making a final decision in connection with the appeal.

B. Scheduling of Appeal

Except for claims involving pre-service, the Trustees will review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within 30 days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination will be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan Administrator will notify the claimant in writing of the

extension, describe the special circumstances and the date as of which the benefit determination will be made.

The Trustees will review a properly filed appeal of a pre-service claim within 30 days after receipt of the appeal.

C. *Appeal Procedures*

A claimant is generally entitled to present the claimant's position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal of a pre-service or post-service claim may be held telephonically by the Trustees, and unless the participation of the claimant or his representative is necessary to develop an adequate record, may be based upon the written record. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

- (1) A claimant may be represented by an attorney or by any other representative of his choosing at his own expense.
- (2) The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits.
- (3) The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

D. *Decision After Appeal Hearing*

The Trustees will issue a written decision on review of a claim (other than a pre-service) as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim will be made within 30 days after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

- (1) The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- (2) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents,

records, and other information relevant to the claimant's claim for benefits.

- (3) A statement of the claimant's right to bring a civil action under ERISA § 502(a).
- (4) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

III. Review of Trustees' Decision

The Plan does not provide for any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Plan's determination after exhausting the claim appeal procedures, the claimant may bring a civil action under ERISA § 502(a). The question on review of the Trustees' determination will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

How To Contact The Plan Administrator

If you have any questions about the grievance and appeal process outlined here, you may contact the Plan Administrator at (503) 224-0048, or toll-free at 1 (800) 547-4457 or you can write or email the Plan Administrator at the following address:

Western States Health & Welfare Trust Fund of the OPEIU
Administrative Office
c/o A & I Benefit Plan Administrators
1220 SW Morrison St., Suite 300
Portland, OR 97205-2222
www.westernstates.aibpa.com

Assistance From The Department Of Consumer And Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: <http://www.cbs.state.or.us/external/ins/>

COORDINATION OF BENEFITS

The Trust dental plan shall not be required to furnish benefits for any expense paid or payable under any other group plan to which any employer contributes or makes payroll deduction. This coordination of benefits provision applies when you or your dependents have health care coverage under more than one plan.

Definitions – The following are definitions of some important terms used in this provision:

- Plan means any of the following which provide benefits or services for, or because of hospital-medical-surgical, dental, vision or drug care as:
 - group, blanket or franchise dental insurance policies issued by insurers including dental care service contractors;
 - other prepaid dental coverage under service plan contracts or under group or individual practice;
 - labor management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans;
 - dental coverage in government programs (as permitted by law);
 - other group-type coverage which is not available to the general public and can be obtained and maintained only because a membership or connection with a particular organization or group.

Each contract or other arrangement for coverage described previously is a separate plan. Also, if an arrangement has two or more parts and the coordination of benefits provisions applies only to one of the two, each of the parts is a separate plan.

- The term “plan” does not include the following:
 - individual or family benefits provided through insurance contracts, subscriber contracts, coverage through health maintenance organization or other prepayment, service, group practice or individual practice plans;
 - school accident-type coverage, covering grammar, high school and college students for accidents only including athletic injuries either on a 24-hour basis or on a “to and from school” basis.
- *This Plan* means the part of this policy that provides benefits for Dental care expenses.

- *Allowable Expense* means any necessary, reasonable and customary item of expense for health care when the item of expense is coverage at least in part by one or more plans covering the person for whom the claim is made. However, if this policy contains more than one plan, then an expense covered by one of the plans and not by the others will be an “allowed expense” for the plan that covers it and not for the others.

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

- *Claim Determination Period* means a calendar year. However, a claim determination period does not include any time before or after the period when the person was insured under this policy.

Order of Benefits Determination Rules – If this Coordination of Benefits provision applies, the order of benefit determination rules shall control. These rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan. The benefits of this Plan may be reduced when under the order of benefit determination rules, another plan determines its benefits first.

In general, when there is a basis for a claim under this Plan and another plan, this Plan is a secondary plan which has its benefits determined after those of the other plan unless:

- The other plan has rules coordinating its benefits with those of this Plan; and
- Both those rules and this Plan’s rules as set forth in the following paragraphs require that this Plan’s benefits be determined before those of the other plan.

This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the plan which covered the person as a dependent.
- **Dependent Child/Parents not separated or Divorced.** Except as stated in the next rule, when this Plan and another plan cover the same child as the dependent of different persons called “parents”:
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but

- If both parents have the same birthday, the benefits of the plan which covers the parent longer are determined before those of the plan which covers the other parent for a shorter period. However, if the other plan does not have the rule described in the immediately preceding paragraph, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of the benefits.
- **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First the plan of the parent with custody of the child;
 - Then, the plan of the spouse of the parent with the custody of the child; and
 - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of these 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 active employee (or as that employee's dependent) are determined before those of a plan which covers that person as an inactive 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 benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the previous rules determines the order of benefits, the benefits of the plan which covered the employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

Effect on the Benefits of This Plan – This section applies when in accordance with the order of benefit determination rules stated previously, this Plan is a secondary plan to one or more other plans. In that event, the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as “the other plans” immediately following this paragraph.

The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for allowable expenses under this Plan in the absence of this coordination of benefits provision; and

- The benefits that would be payable for allowable expenses under the other plans in the absence of provisions with a purpose like that of this coordination of benefits provision whether or not a claim is made,

exceeds those allowable expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Any amount by which a secondary plan's benefits have been reduced in accordance with this section shall be used by the secondary plan to pay allowable expenses not otherwise paid which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information – Certain facts are needed to apply coordination of benefits provisions. The Plan has the right to decide which facts it needs. It may obtain needed facts from or give them to any other organization or person. The Plan need not tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment – Any payment made under another plan may include an amount which should have been paid under this Plan. If so, the Plan may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under the Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided in the forms of services.

Right of Recovery – If the amount of the payments made by the Plan is more than it should have paid under this coordination of benefits provision, the Plan may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies, or
- Other organizations.

The "amount of the payments made" include the reasonable cash value of any benefits provided in the form of services.

A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by the plan which provides benefits in the form of services.

THIRD PARTY RECOVERY

The text in this section applies only to Dental Plans 10, 11 and 12. Consult your dental carrier for specific procedures to their plan.

The Plan excludes dental benefits for any injury or illness caused by the act or omission of another person (known as a "third party"), including any injury or illness covered by a liability policy of the third party, or charges incurred for which coverage is available under an automobile, homeowners, commercial premises, renter's, dental malpractice, or other insurance or liability policy. If a Covered Person has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the Covered Person, may advance benefits pending the resolution of the claim upon the following conditions:

- (1) By accepting or claiming benefits, the Covered Person agrees that the Plan is entitled to first dollar priority and 100% reimbursement from the Covered Person with respect to any judgment, settlement, disputed claim settlement, or other full or partial recovery, award or otherwise, up to the full amount of all benefits provided by the Plan, and unreduced by any legal or other costs expended by the Covered Person, but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the Covered Person is made whole by the recovery, and regardless of the characterization of the recovery.
- (2) The Plan will require a Covered Person to execute and deliver instruments and papers, disclose the circumstances resulting from the injury or illness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). The Plan will also require the Covered Person to sign an agreement to reimburse the Plan from the proceeds of any recovery before the Plan will advance any benefits.
- (3) A Covered Person must do nothing after payment of benefits to prejudice the Plan's right of recovery.
- (4) When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement amount must be paid by the Covered Person into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in an escrow or trust account, the Covered Person or the individual named to hold the funds in trust shall be personally liable for any loss the Trust suffers as a result.

- (5) The Plan may cease advancing benefits if there is a reasonable basis to determine that the Covered Person will not honor the terms of the Plan or the agreement to reimburse, or the Board of Trustees modifies the Plan provisions related to the advancement of benefits. The Plan may also deny coverage for expenses incurred after judgment or settlement of the claim, if such expenses are related to the third party recovery.
- (6) If the Plan is not reimbursed upon recovery on a third party claim, the Plan may bring an action against the Covered Person to enforce its right to reimbursement and/or the agreement to reimburse, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefit payments of the Covered Person and the Covered Person's family members, or by recovery from the source to which benefits were paid.
- (7) If the Plan is forced to bring a legal action against the Covered Person to enforce the terms of this Plan Provision, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

The Covered Person expressly agrees not to raise ERISA jurisdiction and procedural issues and affirms the Plan's right to bring a breach of contract action in state court to enforce the Plan's right to reimbursement under this Plan Provision and affirms the Plan's right to seek a constructive trust in federal court under ERISA 502(a)(3) to recover the funds received by the Covered Person from a third party according to this Plan Provision.

Workers' Compensation

The Plan excludes payments for any work-incurred injury or illness. The only exception would be if you or your enrolled dependent is exempt from state or federal workers' compensation law. If a dispute arises concerning whether an injury or illness is work-incurred, and the Covered Person appeals the denial of a claim by a state or federal workmen's compensation agency or insurer, the Trust may advance payment of the dental charges incurred, to the extent coverage is provided by the Plan, pending resolution of the appeal. Before doing so, the Covered Person must agree in writing to repay 100% of the amount advanced by the Trust or the amount recovered, if less, regardless of whether the Covered Person has been made whole.

Motor Vehicle Coverage

Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payments insurance, and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage. However, the Plan will pay benefits toward expenses over the amount covered by motor vehicle insurance. If the Plan pays benefits before motor vehicle insurance payments are made, the Plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to you or your enrolled dependent and, when applicable, the Plan may recover benefits the Plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which you or your enrolled dependent obtain by exercising your rights against a third party.

You or your enrolled dependent who was involved in a motor vehicle accident may have rights under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In the event that you or your enrolled dependent has rights under both motor vehicle and third party recoveries, before the Plan will pay benefits:

- You must give the Plan Administrator information about any motor vehicle insurance payments which may be available to you or your enrolled dependent; and
- If the Plan asks, you must sign an agreement to hold the proceeds of any recovery in trust for the Plan.

DEFINITIONS

The following is a brief listing of definitions. For a more detailed list, please refer to the definition section of the information provided by your dental carrier.

Calendar Year The time period beginning January 1st and ending on December 31st.

Coinsurance The percentage of the eligible charge that is the Member's responsibility to pay. For example, if the Plan provides benefits at 80 percent of the eligible charge, the other 20 percent is the Member's Coinsurance. Coinsurance does not include any Deductibles or Copayments.

Condition includes, but is not limited to, every illness, disease and injury.

Copayments The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments do not apply toward the Deductible.

Deductible is the amount of covered expenses that are paid by the member 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 those services and supplies that are required for diagnosis or treatment of illness or injury and which, are:

- Consistent with the symptoms or diagnosis and treatment of the enrollee's condition;
- Appropriate with regard to standards of good dental practice;
- Not primarily for the convenience of the enrollee or a provider of services or supplies;
- The least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to a patient. This means, 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 PROFESSIONAL PROVIDER MAY PRESCRIBE, ORDER, RECOMMEND, OR APPROVE A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE THE SERVICE OR SUPPLY A COVERED EXPENSE.

Member The Subscriber or any Dependent, who is eligible, enrolled and covered by PacifiCare.

Non-Participating/Preferred Provider (non-PPO) A Dental Provider who has not contracted with the Company or the Company's designated Preferred Provider Organization.

Out of Pocket Maximum The maximum amount of Copayments and Coinsurance a Member is required to pay for certain Covered Services in a Calendar Year.

Participating/Preferred Provider (PPO) A dental provider who has contracted with the Company or the Company's designated Preferred Provider Organization to provide services, treatment and supplies to a Covered Person at negotiated fees.

Subscriber The person enrolled in the Health Plan for whom the appropriate premiums have been received, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Usual and customary charges are those charges that fall within a range of those most frequently made for services and supplies in a service area by those who provide them.

KAISER DENTAL PLAN

For a full description of your dental benefits and dental office locations and phone numbers, please refer to your Kaiser Permanente dental “A guide to your benefits” booklet and Kaiser Permanente Dental Directory.

If you have questions about your dental plan, call membership services.

From the Portland area.....(503) 813-2000

From all other areas(800) 813-2000

TTY/Text Telephone only.....(800) 324-8007

YOUR DENTAL PLAN

Unless otherwise specified, your Kaiser Permanente dental plan covers a wide range of preventive and restorative dental care when provided in Kaiser Permanente dental offices. All services must be authorized or prescribed by Kaiser Permanente dentists. You are covered for all visits from the first day you become eligible. You also have an emergency benefit. There are no claim forms to fill out unless you receive out-of-area emergency care.

Emergency Care

Care for dental emergencies is available 24 hours a day, every day of the week. Call the Dental Appointment Center to receive advice or arrange to be seen for a dental emergency.

Dental Appointment Center

From Portland.....503-286-6868

From Vancouver.....360-254-9158

From Salem503-370-4311

From Longview360-575-4800

TTY All areas1-800-735-2900

Emergency Benefits

Inside the Service Area.

You must go to a Kaiser Permanente dental office for your dental benefits to apply. You pay \$25 in addition to any other copayments or coinsurance when you receive Emergency or urgent dental services on the same or next business day.

Outside the Service Area.

If you require emergency care when you're outside the service area, you will be reimbursed up to \$100 per incident for services for relief of extreme pain, acute infection, or hemorrhage and for necessary treatment, including local anesthesia and premedication, due to an injury. Elective care and care for conditions that could have been reasonably foreseen are not covered under your emergency benefit. Follow-up and continuing care is covered only at a Kaiser Permanente dental office.

How to use your Kaiser Dental Plan

Choosing a Personal Dentist

Kaiser Permanente asks dental plan members to choose a personal dentist. Having your own dentist and dental hygienist means you can see providers you know and trust when you need dental care providers who are familiar with your dental history and unique concerns. Kaiser Permanente believes this is the most effective way to practice quality dentistry. To choose a dentist, first identify the dental office that's closest to where you live or work. You may want to ask for dentist recommendations from other Kaiser Permanente dental plan members you know. Or Kaiser Permanente's dental Appointment Center can help you choose a dentist and hygienist who are right for you.

Dental Appointment Center

From Portland.....503-286-6868
 From Vancouver.....360-254-9158
 From Salem503-370-4311
 From Longview360-575-4800
 TTY All areas1-800-735-2900

Kaiser Permanente Dental Service Area Zip codes

Service area

The geographic area within which Kaiser Permanente provides service in the Northwest. The service area consists of the following ZIP codes:

In Oregon

Benton: 97330, 97331, 97333, 97339, 97370

Clackamas: 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97222, 97267, 97268

Columbia: All ZIP codes

Hood River: 97014

Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

Marion: 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392

Multnomah: All ZIP codes

Complaints, Grievances, and Appeals

Member Satisfaction

Everyone associated with Kaiser Permanente wants you to receive the best care and service possible. If you have questions about your coverage or how to use our services, or if you need help finding the right dental care resource, call Membership Services. If you have a compliment or suggestion, please call or send a letter to the administrator of the facility where you received care. We'll share your comments with the employees who assisted you and their supervisors.

Discuss any issues about your care with your dental care provider or another member of your dental care team. If you are not satisfied with your dental care provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion within Kaiser Permanente. Most issues can be resolved with your dental care team. If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Oral Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our services, benefits, or other administrative matters, you can file an oral complaint. Examples include, but are not limited to, things like appointment delays, the manner of communication by our staff, or concerns about our policies and procedures. If you have a concern involving a denial of future care or payment for services you already received, refer to "Written Grievances" in your Kaiser Permanente dental "A Guide to your Benefits".

To file a complaint, contact the administrative office in the facility where you are having the problem or contact Membership Services for assistance. Discuss your complaint fully with the staff and be specific about how you want the matter to be resolved.

Send your grievance to:

Member Relations
Kaiser Permanente
500 NE Multnomah St., Suite 100
Portland, OR 97232

If you need assistance filing a grievance, or if your grievance is urgent, contact Member Relations at 503-813-4480 or toll free at 1-800-813-2000 and ask for Member Relations.

SUMMARY OF BENEFITS

Dental office visit charge	\$5 (Applies to each office visit)
Annual deductible	None
Annual benefit maximum	None
BENEFIT	YOU PAY
Preventive and diagnostic services <ul style="list-style-type: none"> • Oral exams and X-rays, teeth cleaning, fluoride treatments, instructions in care of your teeth and gums, and prescribed space maintainers 	No additional charge
Basic restorative services <ul style="list-style-type: none"> • Routine fillings, plastic and stainless steel crowns 	20%
Simple extractions	20%
Oral Surgery <ul style="list-style-type: none"> • Surgical tooth extractions, including diagnosis and evaluation 	20%
Periodontics <ul style="list-style-type: none"> • Root canal and related therapy, including diagnosis and evaluation 	20%
Endodontics <ul style="list-style-type: none"> • Root canal and related therapy, including diagnosis and evaluation 	20%
Major restorative services <ul style="list-style-type: none"> • Gold or porcelain crowns, inlays, and bridge abutments and pontics 	50%
Removable prosthetic services <ul style="list-style-type: none"> • Full or partial dentures, relines and rebases 	50%
Emergency treatment	
<ul style="list-style-type: none"> • From Plan providers: 	\$25 for emergency and urgent care visits on the same or next business day plus any other charges that normally apply
<ul style="list-style-type: none"> • From non-Plan providers 	Balance after you are reimbursed up to \$100 for qualifying claims outside the service area

Orthodontics	50% up to \$1,000; you pay 100% thereafter
Please note:	
<ul style="list-style-type: none"> • You pay \$15 for nitrous oxide for adults and children 13 and older. • You pay 10% of charges for nightguards 	

EXCLUSIONS

The following are not covered:

- Care for conditions that are covered by workers' compensation or that are the employer's responsibility.
- Conditions for which care or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic services.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants and all related services.
- Experimental or investigational treatments, procedures, and services.
- Full mouth reconstruction and occlusal rehabilitation.
- General anesthesia.
- Genetic testing.
- Intravenous sedation.
- Medical, hospital, and certain dental services.
- More than two visits for routine teeth cleaning (oral prophylaxis) treatments in any 12 consecutive month period.
- Prescription drugs.
- Prosthetic devices when necessary or desired following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- Replacement of temporary removable appliances within five years of the date you received the appliance.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Services not approved by a Kaiser Permanente dentist, except as described under "Emergency Treatment".

- ♦ Surgery to correct malocclusions or temporomandibular joint (TMJ) disorders.
- ♦ Work-in-progress before your coverage became effective.

This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims review, and adjudication procedures, please see "A Guide to Your Benefits" (or EOB) or call Membership services. In the case of conflict between this summary and the EOB, the EOB will prevail.

DENTAL PLAN 10

When you or your dependents incur expenses for any eligible dental procedure performed by a legally qualified dentist, the Plan will pay the applicable percentages shown in the following schedule of Dental Procedures, not to exceed the Maximum Benefit Amount.

Schedule of Dental Procedures

1. **Orthodontics:** 50% of reasonable and customary charges.

2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:
 1. Oral examination, including treatment plan, if necessary.
 2. Periapical and bitewing X-rays as required.
 3. Topical fluoride application for family members under the age of 15.
 4. Prophylaxis, including cleaning, scaling and polishing.
 5. Repair of dentures and bridges.
 6. Palliative emergency treatment.
 7. Fillings consisting of silver amalgam, silicate and plastic restoration.
 8. Extractions.
 9. Endodontics, including pulpotomy, pulp capping and root canal treatment.
 10. Space Maintainers.
 11. Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess.
 12. Apicoectomy.

3. **Prosthetic Services.** 50% of usual and customary and reasonable charges (UCR). Prosthetic services include:
 1. Inlays / Onlays.
 2. Crowns.
 3. Bridges, fixed and removable.
 4. Dentures, full and partial except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan shall be limited to the standard procedures for prosthetic services.

Usual, Customery and Reasonable Charges (UCR)

Usual, customary and reasonable charges for dental service, in the area where the services are rendered, are determined by the Plan subject to the following considerations:

- (a) The usual fee is the fee which the individual dentist most frequently charges to the majority of his patients for a similar service.

- (b) The customary fees are those fees which fall within the customary range of fees, charged in a given area by most dentists of similar training and experience for the performance of similar service.
- (c) A charge is reasonable when it meets the usual and customary criteria, or it may be reasonable if, in the opinion of an appropriate professional review committee, it merits special consideration based on complexity of treatment of the particular case.
- (d) The determination of the actual amount payable for any given procedure is within the sole discretion of the Plan, Charges in excess of the usual, customary and reasonable fee, as determined by the Plan, shall be your responsibility.

Deductible Amount

The deductible amount for each covered person during each calendar year is **\$10.00**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family but the maximum deductible for all eligible family members is **\$30** per calendar year.

Maximum Benefit Amount

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000.00 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500.00 for all other dental procedures during each calendar year.

DENTAL EXCLUSIONS AND LIMITATIONS

These dental benefits do not cover expenses incurred by reason of:

1. Accidental bodily injury or sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, unless claim for such loss has been properly denied by the State Industrial Commission or a private industrial carrier;
2. Expenses incurred with respect to any person while he or she was not covered under the Plan;
3. Expenses incurred for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the person was not insured under the plan, or which were offered while the person was insured under the plan but are finally installed or delivered to such a person more than thirty days after termination of coverage;

4. Expenses incurred for treatment by other than a duly licensed dentist or denturist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if treatment is rendered under the supervision and direction of the dentist;
5. Expenses incurred for any replacement of an existing partial or full removable denture of fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework unless evidence satisfactory to the plan is presented that:
 6. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while an individual is insured under the plan; or
 7. the existing denture, bridgework, crown or inlay was installed at least five years prior to its replacement and that the existing denture, bridgework, crown or inlay cannot be made serviceable; or
 8. the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.
9. Expenses incurred for services and supplies that are partially or wholly cosmetic in nature, including charge for personalization or characterization of dentures;
10. Expenses incurred for replacement of a lost, stolen or broken prosthetic device;
11. Services, supplies or treatments provided by or covered under any governmental plan or law, or required or provided by any statute, or provided by any hospital or institution which does not require payment for such expenses in the absence of such group coverage.
12. Expenses incurred for care, treatment, service or supplies which are not necessary for the treatment of disease concerned nor to the extent that any charge for care, treatment, services or supplies are unreasonable;
13. War or act of war (declared or undeclared) or service in the armed forces of any country.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges in connection with such procedure.

DENTAL PLAN 11

When you or your dependents incur expenses for any eligible dental procedure performed by a legally qualified dentist, the Plan will pay the applicable percentages shown in the following schedule of Dental Procedures, not to exceed the Maximum Benefit Amount.

Schedule of Dental Procedures

1. **Orthodontics:** 50% of reasonable and customary charges.

2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:

1. Oral examination, including treatment plan, if necessary.
2. Periapical and bitewing X-rays as required.
3. Topical fluoride application for family members under the age of 15.
4. Prophylaxis, including cleaning, scaling and polishing.
5. Repair of dentures and bridges.
6. Palliative emergency treatment.
7. Fillings consisting of silver amalgam, silicate and plastic restoration.
8. Extractions.
9. Endodontics, including pulpotomy, pulp capping and root canal treatment.
10. Space Maintainers.
11. Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess.
12. Apicoectomy.

3. **Prosthetic Services.** 75% of usual and customary and reasonable charges (UCR). Prosthetic services include:

1. Inlays / Onlays.
2. Crowns.
3. Bridges, fixed and removable.
4. Dentures, full and partial except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan shall be limited to the standard procedures for prosthetic services.

Usual, Customery and Reasonable Charges (UCR)

Usual, customary and reasonable charges for dental service, in the area where the services are rendered, are determined by the Plan subject to the following considerations:

- (a) The usual fee is the fee which the individual dentist most frequently charges to the majority of his patients for a similar service.

(b) The customary fees are those fees which fall within the customary range of fees, charged in a given area by most dentists of similar training and experience for the performance of similar service.

(c) A charge is reasonable when it meets the usual and customary criteria, or it may be reasonable if, in the opinion of an appropriate professional review committee, it merits special consideration based on complexity of treatment of the particular case.

(d) The determination of the actual amount payable for any given procedure is within the sole discretion of the Plan, Charges in excess of the usual, customary and reasonable fee, as determined by the Plan, shall be your responsibility.

Deductible Amount

The deductible amount for each covered person during each calendar year is **\$10.00**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family but the maximum deductible for all eligible family members is **\$30** per calendar year.

Maximum Benefit Amount

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000.00 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500.00 for all other dental procedures during each calendar year.

DENTAL EXCLUSIONS AND LIMITATIONS

These dental benefits do not cover expenses incurred by reason of:

1. Accidental bodily injury or sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, unless claim for such loss has been properly denied by the State Industrial Commission or a private industrial carrier;
2. Expenses incurred with respect to any person while he or she was not covered under the Plan;
3. Expenses incurred for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the person was not insured under the plan, or which were offered while the person was insured under the plan but are finally installed or delivered to such a person more than thirty days after termination of coverage;

4. Expenses incurred for treatment by other than a duly licensed dentist or denturist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if treatment is rendered under the supervision and direction of the dentist;
5. Expenses incurred for any replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework unless evidence satisfactory to the plan is presented that:
 6. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while an individual is insured under the plan; or
 7. the existing denture, bridgework, crown or inlay was installed at least five years prior to its replacement and that the existing denture, bridgework, crown or inlay cannot be made serviceable; or
 8. the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.
9. Expenses incurred for services and supplies that are partially or wholly cosmetic in nature, including charge for personalization or characterization of dentures;
10. Expenses incurred for replacement of a lost, stolen or broken prosthetic device;
11. Services, supplies or treatments provided by or covered under any governmental plan or law, or required or provided by any statute, or provided by any hospital or institution which does not require payment for such expenses in the absence of such group coverage.
12. Expenses incurred for care, treatment, service or supplies which are not necessary for the treatment of disease concerned nor to the extent that any charge for care, treatment, services or supplies are unreasonable;
13. War or act of war (declared or undeclared) or service in the armed forces of any country.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges in connection with such procedure.

DENTAL PLAN 12

When you or your dependents incur expenses for any eligible dental procedure performed by a legally qualified dentist, the Plan will pay the applicable percentages shown in the following schedule of Dental Procedures, not to exceed the Maximum Benefit Amount.

Schedule of Dental Procedures

1. **Orthodontics:** 50% of reasonable and customary charges.

2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:

1. Oral examination, including treatment plan, if necessary.
2. Periapical and bitewing X-rays as required.
3. Topical fluoride application for family members under the age of 15.
4. Prophylaxis, including cleaning, scaling and polishing.
5. Repair of dentures and bridges.
6. Palliative emergency treatment.
7. Fillings consisting of silver amalgam, silicate and plastic restoration.
8. Extractions.
9. Endodontics, including pulpotomy, pulp capping and root canal treatment.
10. Space Maintainers.
11. Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess.
12. Apicoectomy.

3. **Prosthetic Services.** 80% of usual and customary and reasonable charges (UCR). Prosthetic services include:

1. Inlays / Onlays.
2. Crowns.
3. Bridges, fixed and removable.
4. Dentures, full and partial except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan shall be limited to the standard procedures for prosthetic services.

Usual, Customery and Reasonable Charges (UCR)

Usual, customary and reasonable charges for dental service, in the area where the services are rendered, are determined by the Plan subject to the following considerations:

- (a) The usual fee is the fee which the individual dentist most frequently charges to the majority of his patients for a similar service.

(b) The customary fees are those fees which fall within the customary range of fees, charged in a given area by most dentists of similar training and experience for the performance of similar service.

(c) A charge is reasonable when it meets the usual and customary criteria, or it may be reasonable if, in the opinion of an appropriate professional review committee, it merits special consideration based on complexity of treatment of the particular case.

(d) The determination of the actual amount payable for any given procedure is within the sole discretion of the Plan, Charges in excess of the usual, customary and reasonable fee, as determined by the Plan, shall be your responsibility.

Deductible Amount

The deductible amount for each covered person during each calendar year is **\$10.00**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family but the maximum deductible for all eligible family members is **\$30** per calendar year.

Maximum Benefit Amount

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000.00 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500.00 for all other dental procedures during each calendar year.

DENTAL EXCLUSIONS AND LIMITATIONS

These dental benefits do not cover expenses incurred by reason of:

1. Accidental bodily injury or sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, unless claim for such loss has been properly denied by the State Industrial Commission or a private industrial carrier;
2. Expenses incurred with respect to any person while he or she was not covered under the Plan;
3. Expenses incurred for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the person was not insured under the plan, or which were offered while the person was insured under the plan but are finally installed or delivered to such a person more than thirty days after termination of coverage;

4. Expenses incurred for treatment by other than a duly licensed dentist or denturist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if treatment is rendered under the supervision and direction of the dentist;
5. Expenses incurred for any replacement of an existing partial or full removable denture of fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework unless evidence satisfactory to the plan is presented that:
 6. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while an individual is insured under the plan; or
 7. the existing denture, bridgework, crown or inlay was installed at least five years prior to its replacement and that the existing denture, bridgework, crown or inlay cannot be made serviceable; or
 8. the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.
9. Expenses incurred for services and supplies that are partially or wholly cosmetic in nature, including charge for personalization or characterization of dentures;
10. Expenses incurred for replacement of a lost, stolen or broken prosthetic device;
11. Services, supplies or treatments provided by or covered under any governmental plan or law, or required or provided by any statute, or provided by any hospital or institution which does not require payment for such expenses in the absence of such group coverage.
12. Expenses incurred for care, treatment, service or supplies which are not necessary for the treatment of disease concerned nor to the extent that any charge for care, treatment, services or supplies are unreasonable;
13. War or act of war (declared or undeclared) or service in the armed forces of any country.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges in connection with such procedure.

WILLAMETTE DENTAL GROUP, P.C.

Willamette Dental Group, PC (WDG) is our dental service provider for the state of Oregon. The dental benefit underwriters of the Managed Care Dental plan for the residents in the state of Oregon are Willamette Dental Insurance, Inc. The home office for this corporation is located in Hillsboro, Oregon.

A NEW APPROACH

Dental research has shown that the future of dental benefits have changed. It now focuses on cost effective, preventive care that help patients avoid dental disease through early detection and education of proper oral hygiene. Modern dental research also shows that both gum disease and tooth decay are caused by bacterial infection. Through a process of examination, diagnostic treatment and patient education we can control and stop these dental infections. It is our goal to make sure that you know how to access services under this dental plan as well as to provide you with a basic understanding of our dental care philosophy which is to work with patients on their individual Personal Dental Care plan and educate them on good homecare habits.

YOU'LL LIKE OUR DENTAL PLAN

- Predictable Costs – There are no deductibles and no annual maximums. You simply pay any applicable co-pays at the time of service. These co-pays include all lab work.
- Responsive, Flexible and simple Service – There are no claim forms and no pre-authorizations for you to fill out. Just select the WDG office of your choice and pay any applicable co-pays. We'll take care of the rest. Plus, we make scheduling appointments as simple as possible, with a centralized appointment center.
- Extensive Benefits – Your dentist will work with you to maintain your dental health through routine exams and other preventive services. Preventive services such as cleanings, periodic x-rays, sealants, fillings and fluoride applications are covered in full after the office visit co-pay so that you and your family will maintain excellent dental health.

Major dental work such as crowns, bridges and orthodontics are also covered under this plan with a modest co-pay. Services rendered at our offices are subject to an office visit charge which is not included in the co-pay amount,

- Experience – With over 25 years of dental care experience, WDG dentists and offices will provide you with care you can count on.

- **Quality Improvement_** WDG has an extensive Quality Improvement program. Our Quality Assurance staff includes practicing dentists who review and audit charts to ensure the highest quality of service and assure our standards exceed state requirements. Quality Assurance begins with the recruitment of accomplished dentists and staff members. These dentists must meet strict credentialing measures. All dentists, both general and board certified specialists are salaried employees of WDG. As employees of WDG, the dentists and specialists all practice under the same treatment planning guidelines. Quality coverage which includes health and safety measures is extremely important to us. You can be assured our health protection control and safety measures exceed OSHA and state requirements. It is these attributes that we speak of that have made WDG one of the largest dental practices in the United States.

HERE'S HOW OUR PLAN WORKS

You may select any dentist at any WDG clinic to receive the services available under this plan. All routine appointments will be scheduled with your primary dentist unless specified at the time the appointment is arranged. There is no need for everyone in your family to visit the same office location; each family member may select his or her own dentist and office location. You will be responsible for paying any service copayments for major dental work at the time services are rendered.

CHOOSING A PROVIDER

The primary care dentist that you select will coordinate all of your dental care needs. Your primary care dentist offers a personal, individual approach to dental treatment by becoming familiar with you and your dental history. In order to receive benefits under this plan, you must receive treatment at a WDG clinic, except in the case of emergency dental service for pain, bleeding or swelling that is out of the service area. Unless a specific WDG dentist is requested we will make an appointment for you with the first available dentist at the location of your choice. We believe in consistency of care. In order to establish a good dentist-patient relationship future appointments will be scheduled with your primary care dentist unless we are advised of a permanent change you would like to make. Just let us know when you call to schedule your next appointment.

SCHEDULING APPOINTMENTS

To schedule an appointment at the office most conveniently located near you and to select your dentist, call the Willamette Dental appointment center: in the Portland metro area: (503) 644-3200, outside Portland metro area 1-800-461-8994. Please schedule your first visit four to six weeks in advance and remember that as with most other health care providers certain days and times may be more popular, so it may be longer to schedule an appointment at those times. Of course Willamette Dental staff are always willing to work with you to accommodate your scheduling needs.

YOUR FIRST VISIT

As a new patient, you can expect your first visit to include:

- A thorough examination for gum disease and tooth decay.
- Diagnostic x-rays.
- Discussion of your medical and dental history.
- Fluoride and decay-reducing treatment for children under age 12.
- Review of the cause of decay and gum disease.
- Demonstrations of effective methods of brushing and flossing.
- A head and neck cancer screening.
- A Personal Dental Care Plan to meet your individual needs and to help you maintain superior dental health.

Based on our finding at this time, we will determine your Personal Dental Care Plan and schedule your next appointment for your continuing care with the hygienist. As part of your Personal Dental Care plan, your dentists and hygienists will work closely with you on a preventative program to minimize costly dental problems in the future.

FOLLOW UP CARE

Based on the Personal Dental Care Plan established by your dentists, you will schedule any necessary appointments. Some patients may require several hygiene appointments, others with healthy teeth and gums may require only annual continuing care appointments with the hygienists. Your dentist will discuss with you what they recommend for your Personal Dental Care plan.

HOW IT WORKS

- You may select any WDG dentist at any of our locations to receive services under this dental plan.
- Just call toll-free 800-461-8994 to activate your account and schedule your first appointment.

DENTAL PLAN

BENEFIT

Maximum Benefit
 Deductible
 Visit Charge
 Routine exams, fillings, sealants, cleanings, and fluoride treatments to age 23
 Initial exam & x-ray
 Simple extractions
 Surgical extractions
 Gingivectomy
 Osseous surgery

WDG PLAN BENEFITS

No maximum benefit
 No Deductible
 \$5, includes ortho
 Fully covered (after visit charge)
 Fully Covered (after visit charge)
 Fully Covered (after visit charge)
 \$60 co-pay
 \$120 co-pay per quad
 \$120 co-pay per quad

BENEFIT

Root planning
 Crowns
 Root canal
 Single
 Double
 Three +
 Bridge pontics
 Dentures per upper/lower

WDG PLAN BENEFITS

\$40 co-pay per quad
 \$120 co-pay

 \$40 co-pay
 \$80 co-pay
 \$120 co-pay
 \$120 co-pay
 \$120 co-pay

FULL ORTHODONTIA

Orthodontic Benefit \$2,400 plus \$5 copay each visit

LOCATIONS

Appointments: 503-952-2100

Outside of Area: 800-461-8994

Customer Service: 503-952-2000 x 65200

Out of Area: 800-460-7644

WDG offices are located in Oregon, Washington and Idaho. Please contact Customer Service for locations or find locations on line at www.willamettedental.com.

SPECIALTY SERVICES AND ORTHODONTICS

WDG staff dentists provide a full range of general and specialty dental services. For most treatment, you will see your selected primary dentist; however, they may refer you for a covered dental service to a specialty provider who is not at a WDG office. Services will be covered up to your contract specifications for those procedures authorized by your referring WDG dentist. Your plan does not cover specialty services unless you are referred by a WDG dentist. If you have any questions regarding these services, please talk with one of the Patient Relations Representatives.

ORTHODONTIC TREATMENT PLAN

Your WDG orthodontist will prepare a Personal Dental Care Plan prior to rendering orthodontic services. The Personal Dental Care Plan is based on an exam that must take place while you are covered under this plan. It must also show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care. Your copayments will be determined by the extent of treatment rendered. Once active treatment ends, there is no charge for additional orthodontic services for a three-year period provided the post treatment plan is followed and appointments are kept. You will be required to put a portion of this orthodontics copayment down and may pay the remainder of the balance in installments.

Orthodontic benefits will be determined by one of the following treatment approaches.

Pre-Orthodontic Services

Prior to undergoing orthodontic treatment you will be required to have a pre-orthodontic consultation with our orthodontist to discuss your individual case. Your or your enrolled dependents will be required to pay a service copayment to cover consultations, x-ray, study models and other services at the time these services are rendered. The service copayment will be determined by the extent of the preorthodontic services provided. However, should you or your enrolled dependent undergo orthodontic treatment the pre-orthodontia service copayment will be deducted from either the partial or full orthodontic service copayment.

Partial Orthodontic Treatment

If you have already started orthodontic treatment prior to coming onto the Willamette Dental Insurance Plan, your orthodontia treatment will be prorated according to the extent of orthodontia services provided.

Full Orthodontia Treatment

The length of treatment for extensive malocclusions is not limited. Please refer to the schedule of covered services and co-pays for your particular plan.

Exclusions and Limitations to Orthodontic Services

If insurance terminates prior to completion of orthodontic treatment the remainder of treatment will be prorated based on fee-for-service rates. If orthodontic treatment benefits stop before the end of the prescribed treatment period, benefits will continue through the end of the month in which the orthodontic coverage was terminated. There may be additional charges for orthodontic services rendered if treatment continues after the termination or change in your dental coverage.

EMERGENCY DENTAL CARE

To best serve you, WDG has Doctors on call 24 hours a day. If an emergency situation occurs, we will provide emergency care within approximately 24 hours. Emergency care includes evaluation and treatment of immediate emergent problems.

Emergency dental situations are defined as:

- Extreme pain or infection
- Bleeding or swelling
- Traumatic injuries to the teeth and / or gums

Urgent dental situations should be taken care of as soon as possible, but do not necessarily need immediate attention. These include:

- Lost or cracked fillings
- A broken tooth
- Crowns that have fallen off or broken

Emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy or prosthetic benefits. Any necessary follow-up care will be scheduled with your regularly selected dentist or a WDG specialist as needed. If you have a dental emergency more than 50 miles away from any of our offices and are seeking relief of pain, swelling or bleeding, we will reimburse you a maximum of \$50. WDG's dental plan does not provide prescription coverage.

EXCLUSIONS AND LIMITATIONS (Please refer to the WDG Evidence of Coverage Certificate for further detail regarding these exclusions and limitations.)

- Treatment prior to or after insurance
- Services that are not necessary dental care
- Services and supplies related to the diagnosis or treatment of Temporomandibular Joint (TMJ)
- Dental implants
- Experimental or investigational procedures
- Cosmetic/reconstruction services and Supplies (dental)
- Service related conditions
- Gnathologic recordings
- Surgery for fractures, cysts or tumors
- Appliances and restorations
- Services otherwise available
- Services provided by a dentist or denturist which are beyond the scope of his or her license
- Services by other providers
- Study Models
- Lost, stolen, or broken appliances
- General anesthesia
- Third party liability
- Motor vehicle coverage
- Work-related conditions
- Benefits not stated

The fact that a dentist or denturist may prescribe, order, or approve a service or supply does not, of itself, make the service or supply "necessary".

Clinic Hours and Locations

For your convenience WDG dental offices are open six days a week, Monday through Saturday from 7:00 am to 6:00 pm. Missed appointments without 24 hour prior notice will result in a missed appointment charge. This charge is not covered under the WDG Plan and will be your responsibility to pay.

Calling Patient Relations

We know that you may have questions about your coverage or other issues. Willamette Dental Group, P.C. will provide you with friendly service teams to help you resolve your questions quickly. If you have questions regarding clinical care, appointments, or your treatment plan, please contact Willamette Dental Group's Patient Relations team in the Portland area at: 503.952-2000, outside the Portland area at: 1-800-460-7644.

Administered by:

A & I Benefit Plan Administrators
1220 SW Morrison St., Suite 300
Portland, OR 97205-2222

(503) 224-0048
Toll-Free 1-800-547-4457

Fax (503) 228-0149

www.westernstates.aibpa.com

Arranged by:

B.W. Reed Benefits LLC
PO Box 12469
Portland, Oregon 97212

Underwritten by:

Dental:

Kaiser Permanente
Willamette Dental Group

Dental Plans 10, 11 and 12:
Self-Funded Through the Trust