Oregon Group Dental Plan

The Nelson Trust
Active Participant Plan
Delta Dental PPO Plan

Effective date: January 1, 2021
Group number: 10004450

Oregon Dental Service doing business as Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

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SECTION 1. WELCOME

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

The Plan is self-funded and The Nelson Trust has contracted with Delta Dental Plan of Oregon (abbreviated as Delta Dental) to provide dental claims management and other administrative services.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Delta Dental's personalized Member website, Member Dashboard, at www.deltadentalor.com. Member Dashboard is available 24 hours a day, 7 days a week allowing Members to access Plan information whenever it is convenient.

Delta Dental reserves the right to monitor telephone conversations and email communications between its employees and Members for legitimate business purposes as determined by Delta Dental, in accordance with applicable law.

The Trust may change or replace this handbook at any time, without the consent of any Member. The most current handbook is available on Member Dashboard, accessed through the Delta Dental website. All Plan provisions are governed by the Trust's agreement with Delta Dental. This handbook may not contain every Plan provision.

IMPORTANT NOTICE

Refer to the Active Participant Plan Summary Plan Description for an explanation of eligibility requirements and eligibility rules. The dental benefits described herein supersede the dental benefits in any previous handbook.

The Trustees of The Nelson Trust established this Plan and funds benefits with contributions negotiated through collective bargaining. The benefits described in the handbook, while intended to remain in effect indefinitely, cannot be guaranteed for any definite period of time. The Plan will continue for present and future active Members as determined by the Trustees. Plan benefits are not guaranteed lifetime benefits.

The Trustees reserve the right, at any time, to make any changes in the Plan that they deem necessary including benefit and eligibility changes, termination of all, or a portion of, the coverage or to require or change monthly employee contributions.

This handbook is furnished for the purpose of giving a brief and clear summary of dental benefits available to Members under the Plan. It describes the dental coverages provided by the Plan in general terms. All benefits are governed by the terms of the Plan, which includes the agreement between Delta Dental and the Trust. Therefore, if there is ambiguity or conflict between this handbook and the Plan, the Plan will control.

Eligibility questions should be directed to the Plan Administrator (see next page).

The Trust does not guarantee the availability of any particular Dentist, Dental Provider or any services rendered under the Plan.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to **Member Dashboard**)
www.DeltaDentalOR.com
Includes many helpful features, such as Find Care (which can be used to find an in-network Dentist)

Dental Customer Service Department
Toll-free 888-217-2365
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

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

The Nelson Trust's Plan Administrator:
Mailing Address:
The Nelson Trust
PMB #116
5331 S Macadam Avenue, Suite 258
Portland, OR 97239-3871

Physical Address:
BeneSys, Inc.
5331 S Macadam Avenue, Suite 220
Portland, Oregon 97239-3871
Phone 503-222-7696 toll-free 800-811-8853 fax 503-228-0149

Website:
www.nelsonbenefits.org

2.2 IDENTIFICATION CARD

After enrolling, Members will receive ID (identification) cards that will include the Delta Dental Group number and the Subscriber identification number. Members will need to present the card each time they receive services. Members may go to Member Dashboard or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK

See Network Information (section 3.1) for details about how networks work.

Dental network
Delta Dental Premier Network
Delta Dental PPO Network

2.4 OTHER RESOURCES

Additional Member resources providing general information about the Plan can be found in section 9, section 11 and section 13.

SECTION 3. USING THE PLAN

For questions about the Plan, Members should contact Customer Service. This handbook describes the benefits of the Plan. It is the Member's responsibility to review this handbook carefully and to be aware of the Plan's limitations and exclusions.

At a first appointment, Members should tell the Dentist or Dental Provider that they have dental benefits administered by Delta Dental. Members will need to provide their Subscriber identification number and Delta Dental Group number to the Dentist or Dental Provider. These numbers are located on the ID card.

3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. This Plan offers the same annual maximum Plan payment limit, Deductibles, and Coinsurance whether a Member sees an in-network or Out-of-Network Dentist or Dental Provider.

If Members choose an in-network Dentist (available on Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the Dentist's office.

Out-of-Network Dental Providers may not be willing to submit claims to Delta Dental. As a result, Members who choose to see an Out-of-Network Dental Provider may be required to submit claims and supporting documentation to Delta Dental for processing. Note that the Dental Provider may ask for payment up front.

For Members outside Oregon, Delta Dental national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Members needing dental care may go to any dental office. However, there are differences in reimbursement by Delta Dental for Delta Dental PPO Dentists, Delta Dental Premier Dentists and Out-of-Network Dental Providers. While a Member may choose the services of any Dentist, Delta Dental does not guarantee the availability of any particular Dentist.

3.1.1 In-Network Delta Dental Dentists

When using a Delta Dental PPO Dentist or Delta Dental Premier Dentist, the Dentist may not charge the Member the difference between the Maximum Plan Allowance and the billed amount for Covered Services. The Dentist may bill the Member for the entire cost of a noncovered or excluded service.

Payment to a Delta Dental PPO Dentist will be the lesser of the PPO Fee Schedule and the Dentist's actual billed fees.

Payment to a Delta Dental Premier Dentist will be the lesser of the Dentist's filed or contracted fee with Delta Dental or fees actually charged.

3.1.2 Out-of-Network Dentists

Payment to an Out-of-Network Dentist or Dental Provider is paid at the applicable Coinsurance and limited to the amount in the PPO Fee Schedule. The Member may have to pay the difference between the PPO Fee Schedule amount and the billed charge.

The explanation of benefits (EOB) issued after a claim is processed will show the Maximum Plan Allowance and the amount owed to the Dental Provider. Retain the EOB so it can be compared against the Dental Provider's bill to confirm its accuracy.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. While a predetermination is not required, this is a service available to Members who would like to request one before treatment begins. The Dentist may submit a predetermination request to Delta Dental which will be processed according to the Plan's current benefits and returned to the Dentist with an estimate of what the Plan would pay. The Member and their Dentist should review the information and the charges they are liable to pay before beginning treatment.

SECTION 4. BENEFITS AND LIMITATIONS

The Plan covers the services listed when performed by a Dentist or Dental Provider, and only when determined to be Dentally Necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. Delta Dental's dental consultants and dental director shall determine these standards.

Payment of covered expenses is always limited to the Maximum Plan Allowance and annual maximum Plan payment limit. In no case will benefits be paid for services provided beyond the scope of a Dentist's or Dental Provider's license, certificate or registration. Services covered under the medical portion of a Member's medical plan are not covered under this Plan except when related to an accident.

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

All annual or per year benefits or Cost Sharing accrue based on a calendar year (January 1 through December 31) or portion thereof. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

Deductible: $50
Per Member (not to exceed $150 per family) per calendar year, or portion thereof
Deductible applies to covered Class II and Class III services

Annual maximum Plan payment limit: $1,500
Per Member per calendar year, or portion thereof.
All Covered Services apply to the annual maximum Plan payment limit.
Members are responsible for expenses that exceed the annual maximum Plan payment limit.

4.1 CLASS I:
COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE

4.1.1 Diagnostic

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

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive examinations (including problem focused comprehensive examinations) or consultations are covered once in any 6-month period
ii. Limited examinations or re-evaluations are covered twice per year
iii. A separate charge for teledentistry is not covered. Teledentistry is included in the fees for overall patient management.
iv. Complete series x-rays or a panoramic film is covered once in any 5-year period
v. Supplementary bitewing x-rays are covered once in any 12-month period
vi. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
vii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal and bitewing

4.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Periodontal Maintenance
iii. Topical application of fluoride
iv. Interim caries arresting medicament application
v. Sealants
vi. Space maintainers

b. Preventive Limitations:

i. Prophylaxis (cleaning) is covered once in any 6-month period†.
ii. Periodontal Maintenance is covered once in any 3-month period†
iii. Adult Prophylaxis is only covered for Members age 12 and over. Child Prophylaxis is covered for Members under age 12.
iv. Topical application of fluoride is covered once in any 6-month period for Members under age 19. For Members age 19 and over, topical application of fluoride is covered once in any 6-month period if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
v. Interim caries arresting medicament application is covered twice per tooth per year.
vi. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
vii. Space maintainers are a benefit for one space per quadrant per lifetime for Members under age 14. Space maintainers for primary Anterior teeth, missing permanent teeth or for Members age 14 and over are not covered.

†Additional cleaning benefit is available for Members with diabetes and Members in their third trimester of pregnancy. To be eligible for this additional benefit, Members must be enrolled in the Oral Health, Total Health program (see section 5.1).

4.2 CLASS II:
COVERED SERVICES PAID AT 80% OF THE MAXIMUM PLAN ALLOWANCE

4.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings for the treatment of decay
ii. Stainless steel crowns

b. Restorative Limitations:

i. Restorations are not covered within 3 months of interim caries arresting medicament application.
ii. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided.
iii. Crown buildups are considered to be included in the crown Restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains.
v. Replacement of a stainless steel crown by the same Dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.
vi. Additional limitations when teeth are restored with crowns or Cast Restorations are in section 4.3.1.

4.2.2 Oral Surgery

a. Oral Surgery Services:

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

b. Oral Surgery Limitations:

i. A separate, additional charge for Alveoloplasty done in conjunction with removal of teeth is not covered.
ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
iii. A separate charge for post-operative care done within 30 days following an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
iv. Brush biopsy is covered once in any 6-month period. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

4.2.3 Endodontic

a. Endodontic Services:

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

b. Endodontic Limitations:

i. A separate charge for cultures is not covered.
ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. A separate charge for pulp capping is not covered. Pulp capping is considered to be included in the fee for the final restoration.
iv. Retreatment of the same tooth by the same Dentist within a 2-year period of a root canal is not eligible for additional coverage. The cost of retreatment by the same Dentist is included in the charge for the original care.
v. A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.

4.2.4 Periodontic

a. Periodontic Services:

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

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 6-month period.
ii. Periodontal maintenance is covered under Class I, Preventive.
iii. A separate charge for post-operative care done within 6 months following periodontal surgery is not covered.
iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
v. Bone replacement grafts are covered once per single tooth or multiple teeth within a quadrant in a 3-year period.
vi. Additional periodontal surgical procedures by the same Dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
vii. For Members under age 19, full mouth Debridement is limited to once in a 2-year period. For Member age 19 or older, full mouth Debridement is limited to once in a 2-year period, only if there has been no cleaning (Prophylaxis, Periodontal Maintenance) within a 2-year period.

4.2.5 Anesthesia Services

a. General anesthesia or IV sedation
Covered only:

i. In conjunction with covered surgical procedures performed in a dental office
ii. When necessary due to concurrent medical conditions

4.3 CLASS III:
COVERED SERVICES PAID AT 60% OF THE MAXIMUM PLAN ALLOWANCE

4.3.1 Restorative

a. Restorative Services:

i. Cast Restorations, such as crowns, onlays or lab Veneers, necessary to restore decayed or Broken teeth to a state of functional acceptability.

b. Restorative Limitations:

i. Cast Restorations (including Pontics) are covered once in a 7-year period on any tooth. See 4.2.1 for limitations on buildups.
ii. Porcelain Restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iii. If a tooth can be restored by an Amalgam or composite filling, but another type of Restoration is selected by the Member or Dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.
iv. Restorations are not covered within 3 months of interim caries arresting medicament application.
v. A separate, additional charge for repair of a restoration done within 2 years of the original restoration is not covered.
vi. Re-cement or re-bond of a crown, inlay, or veneer, by the same dentist, is limited to once per lifetime.

4.3.2 Prosthodontic

a. Prosthodontic Services:

i. Bridges
ii. Partial and complete dentures
iii. Denture Relines
iv. Repair of an existing prosthetic device
v. Implants and implant maintenance
vi. Surgical stent in conjunction with a covered surgical procedure

b. Prosthodontic Limitations:

i. A Bridge or a full or partial denture will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a Cast Restoration benefit in the last 7 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an Anterior tooth or for missing Anterior permanent teeth of Members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for Cast Restorations for partial denture Retainer teeth unless the tooth requires a Cast Restoration due to being decayed or Broken.

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

v. Surgical placement and removal of Implants are covered. Implant placement and Implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an Implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years. The Plan will also cover:
   A. The final crown and implant Abutment over a single Implant. This benefit is limited to once per tooth or tooth space over the lifetime of the Implant; or
   B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the Implant is placed to support a prosthetic device; or
   C. The final Implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space over the lifetime of the Implant.
   D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth.
   E. These benefits or alternate benefits are not provided if the tooth, Implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

vi. The re-cement or re-bond of an Implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.

vii. Fixed Bridges or removable cast partial dentures are not covered for Members under age 16.

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

ix. Prosthodontics are not covered within 3 months of interim caries arresting medicament application.

4.3.1 Other

a. Other Services

i. Athletic mouthguard
ii. Nightguard (Occlusal guard)

a. Other Limitations:

i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.

ii. A nightguard (occlusal guard) is covered once every 5-year period at 100% up to $150 maximum with no deductible. Members are responsible for any amount above the $150 maximum. Repair, reline and adjustment of occlusal guard is covered once every 12-month period. Over-the-counter nightguards are excluded.

iii. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

4.4 GENERAL LIMITATION – OPTIONAL SERVICES

Some treatment options are more expensive than others. For example, treating a cavity with a filling instead of a crown. The Plan will pay the applicable percentage of the Maximum Plan Allowance for the least costly treatment that is functionally adequate. Please check with the Dentist about all the options and their costs or request a predetermination before treatment begins.

SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

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

5.1 ORAL HEALTH, TOTAL HEALTH PROGRAM

The Plan has a program that provides additional cleanings (Prophylaxis or Periodontal Maintenance) for Members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 4.

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

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

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

Members should talk to their Dentist about scheduling a routine cleaning or Periodontal Maintenance during the third trimester of pregnancy. Pregnant Members are eligible for a cleaning in the third trimester of pregnancy regardless of when they had a previous cleaning.

5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a Member can contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on Member Dashboard. Members with diabetes must include proof of diagnosis.

SECTION 6. EXCLUSIONS

This section contains Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections of this handbook. These services or supplies are not covered even if they are Dentally Necessary, they are recommended or provided by a Dentist or Dental Provider, or they relate to a covered condition.

Analgesics
Substances used for pain relief.

Anesthesia or Sedation
Local anesthetics, nitrous oxide, general anesthesia, other prescribed medications, and/or IV sedation except as stated in section 4.2.5.

Behavior Management
Additional services, time or assistance to control the actions of a Member.

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

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

Coping
A thin covering over the visible part of a tooth, usually without anatomic conformity.

Cosmetic Services
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion.

Duplication and Interpretation of X-rays or Records
Administrative and other services in support of covered dental services are not covered.

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

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

Gnathologic Recordings
Services to observe the relationship of opposing teeth, including occlusion analysis.

Hypnosis
Inducing a state of consciousness in which a person is highly responsive to suggestion or direction for the purpose of changing behavior.

Illegal Acts
Services and supplies for treatment of an injury or condition caused by or arising directly from a Member's illegal act. This exclusion also includes any expense caused by or arising out of illegal acts related to riot, declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

Inmates
Services and supplies a Member receives while in the custody of any state, federal, county or municipal law enforcement authorities or while in jail or prison.

Instructions or Training
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction.

Localized Delivery of Antimicrobial Agents
Time released antibiotics to remove bacteria from below the gumline.

Maxillofacial Prosthetics
Except for surgical stents as stated in section 4.3.2.

Medications
Substance used for the purpose of treating a condition.

Missed Appointment Charges
Fee charged for appointments missed without timely cancelling in advance.

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

Orthodontia
Services and supplies to correct malocclusioned teeth.

Over the Counter
Including over the counter occlusal guards and athletic mouthguards.

Periodontal Charting
Measuring and recording the space between a tooth and the gum tissue.

Precision Attachments
Devices to stabilize or retain a prosthesis when seated in the mouth.

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

Self-Treatment
Services provided by a Member to themselves.

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

Services on Tongue, Lip, or Cheek
Services provided on tongue, lip or cheek.

Services Otherwise Available
Including those services or supplies:

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

Taxes
A sum of money collected by a government for its support or for specific facilities or services, levied upon incomes, property, sales, etc.

Third Party Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 8.3.2).

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

Treatment After Coverage Ends
The only exception is for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a Member's eligibility ends. This exception is not applicable if the Trust transfers its Plan to another claims administrator.

Treatment Before Coverage Begins
Services and supplies that were provided before the Member's coverage under the Plan began.

Treatment Not Dentally Necessary
Including services:

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

c. with poor prognosis.

Treatment of Closed Fractures
Closed fractures of maxilla, mandible or other facial bones are not dental services.

SECTION 7. ELIGIBILITY AND ENROLLMENT

Eligibility and coverage rules for this dental Plan are governed by general Trust eligibility rules for active employees. Members should refer to the Summary Plan Description provided by the Plan Administrator for an explanation of the Plan's eligibility rules.

SECTION 8. CLAIMS ADMINISTRATION & PAYMENT

8.1 SUBMISSION AND PAYMENT OF CLAIMS

8.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

8.1.2 Explanation of Benefits (EOB)

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

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

8.1.3 Claim Inquiries

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

8.1.4 Time Frames for Processing Claims

If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond Delta Dental's control, a notice of delay will be sent to the Member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then finish processing the claim and send an EOB to the Member no more than 45 days after receiving the claim. If more information is needed to process the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 8.1.1.

8.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

8.2.1 Definitions

For purposes of section 8.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Delta Dental informing that a person is not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Eligibility to participate in the Plan
b. Annual benefit limit or other limitation on otherwise Covered Services
c. Utilization review (described below)
d. Limitations or exclusions described in Section 4 and Section 6), including a decision that an item or service is experimental or investigational or not Dentally Necessary

Appeal is a written request by a Member or the Member's representative for Delta Dental to review an adverse benefit determination.

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

8.2.2 Time Limit for Submitting Appeals

A member has **180 days** from receipt of a notification of an adverse benefit determination to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the Member will lose the right to any appeal. In addition, the right to file suit in court may be lost, as the Member will have failed to exhaust the internal appeal rights, which is generally a prerequisite to bringing suit.

8.2.3 The Review Process

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

The timelines in the sections below do not apply when the Member does not reasonably cooperate, or circumstances beyond the control of either party (Delta Dental or the Member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

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

8.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records and other information relating to the claim for benefits may be submitted. Delta Dental's investigation of the appeal will be made by persons who were not involved in the original decision.

When an investigation is finished, Delta Dental will send a written notice of the decision to the Member, including the reason for the decision. The investigation will be completed and notice sent within 30 days of receipt of the appeal.

8.2.5 Second Level Appeal

A Member who disagrees with the decision on the first level appeal may ask for a review of the decision. The second level appeal must be submitted in writing within 180 days of the date of Delta Dental's action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions. The Member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

If a Member elects to request a second level appeal, any statute of limitation or timeline pertaining to rights for further review, such as a lawsuit under ERISA Section 502(a), will be tolled during the voluntary review process until a decision is made.

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

8.2.6 Third Step – Voluntary Appeal to Board of Trustees Claims Review Committee

Members may appeal directly to the Claims Review Committee of the Board of Trustees. This is a voluntary appeal. A Member is not required to use this third step appeal process. However, if the Member elects to appeal to the Claims Review Committee any statute of limitations or timeline relating to rights for further review, such as a lawsuit under ERISA Section 503(a), will be tolled during this voluntary appeal process until a decision is made.

Refer to the Summary Plan Description provided by the Plan Administrator for the specific rules relating to an appeal to the Claims Review Committee.

8.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

8.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when a Member has dental coverage under more than one plan.

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

8.3.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the Member as other than a Dependent, (e.g., an employee, Member of an organization, primary insured or retiree) then that plan will determine its benefits before a plan that covers the Member as a Dependent. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent and primary to

the plan covering the Member as other than a Dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.

b. **Dependent Child/Parents Married or Living Together.** If the Member is a Dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)

c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the Member is a Dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent

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

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

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

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

h. **Longer/Shorter Length of Coverage.** The plan that covered a Member longer is the primary plan and the plan that covered the Member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

8.3.1.2 How COB Works

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

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

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

8.3.1.3 Effect on the Benefits of This Plan

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

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

8.3.1.4 Credit Savings

Where this Plan does not have to pay its full benefits because of COB, the savings will be credited to the Member for the plan year. These savings would be applied to any unpaid allowable expense during the plan year.

8.3.1.5 COB and Plan Limits

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

8.3.1.6 Definitions

For purposes of this section, the following definitions apply:

Allowable expense means a dental expense, including Cost Sharing, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an allowable expense.

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

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

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

Complying plan is a plan that follows these COB rules.

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

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

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

Plan includes:

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

Plan does not include:

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

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

This Plan refers to the dental expenses in section 4 to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of this Group dental plan providing dental benefits is separate from this Plan. A group dental plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

8.3.2 Third Party Liability

A Member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover benefits when a third party may be legally responsible to pay for those benefits. Usually third party recovery takes a long time. During the third party recovery process, the Plan will pay a Member's expenses if the Member agrees to reimburse the Plan in full of what it pays on the Member's expenses from any financial recovery the Member may receive. The Member will reimburse the Plan from what may be recoverable from a third party even if the Member has not been made whole.

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

8.3.2.1 Definitions:

For purposes of section 8.3.2, the following definitions apply:

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

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

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

8.3.2.2 Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the Member. The Member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan's provisions even if the Member has not been made whole.

8.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a Member, and the Member's attorney, if any, to protect its recovery rights. The following rules apply even if the Member has not been made whole:

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

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

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

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

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

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

8.3.2.4 Additional Provisions

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

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

    i. Signing and delivering any documents Delta Dental reasonably requires to protect the Plan's rights, including a Third Party Questionnaire and Agreement. If the Member has retained an attorney, then the attorney must also sign the agreement.

The Plan will not be required to pay benefits until the agreement is properly signed and returned

ii. Providing any information to Delta Dental relevant to the application of the provisions of section 8.3.2 including all information available to the Member, or any representative or attorney representing the Member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.

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

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

b. The Member agrees, for the Member and any representatives the Member appoints at any time, that they are obligated to notify Delta Dental in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the Member is seeking recovery of benefits paid by the Plan from the third party.

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

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

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

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

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

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

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

SECTION 9. MISCELLANEOUS PROVISIONS

9.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the Member must give or authorize a provider to give Delta Dental any information Delta Dental needs to pay benefits under the Plan. Delta Dental may release to or collect from any person or organization information needed to process the claim.

9.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

9.3 TRANSFER OF BENEFITS

Only Members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental or the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider upon a Member's written request.

9.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan makes a payment for a Member to which the Member is not entitled, or pays a person who is not eligible for payments at all, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a Member even if the mistaken payment was not made on that Member's behalf. Once a mistake has been identified in any of the provisions of the Plan, it can be rectified immediately. Any prior mistake does not permanently change the Plan.

9.5 CORRECTION OF PAYMENTS

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

9.6 LIMITATION OF LIABILITY

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

9.7 PROVIDER REIMBURSEMENTS

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

9.8 INDEPENDENT CONTRACTOR DISCLAIMER

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

9.9 NO WAIVER

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

9.10 TRUST IS THE AGENT

The Trust is the Members' agent for all purposes under the Plan. The Trust is not the agent of Delta Dental.

9.11 GOVERNING LAW

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

9.12 WHERE ANY LEGAL ACTION MUST BE FILED

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

9.13 TIME LIMIT FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan by a Member or any third party must be filed in court no more than 3 years after the date the claim was filed (see section 8.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

9.14 RESCISSION

The Plan may rescind a Member's coverage back to the Member's effective date, or deny claims at any time for fraud, intentional material misrepresentation, omission or concealment by a Member which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. Should the Plan terminate coverage under this section, the Plan may, to the extent permitted by law, deny future enrollment of the Members under any Delta Dental policy or contract or the contract of any affiliates.

SECTION 10. CONTINUATION OF DENTAL COVERAGE

Eligibility for Continuation of Dental Coverage and the terms under which dental coverage may be continued are the same as set forth in the Summary Plan Description available from the Plan Administrator.

SECTION 11. ERISA DUTIES

The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should refer to the Summary Plan Description provided by the Plan Administrator for an explanation of ERISA rights and protections.

SECTION 12. DEFINITIONS

Abutment is a connection device that attaches a Restoration to the root form implant.

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

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

Anterior refers to teeth located at the front of the mouth (tooth chart in section 13).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 13).

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

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

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

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

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

Cost Sharing is the share of costs a Member must pay when receiving a Covered Service, including Deductible or Coinsurance. Cost Sharing does not include premiums, balance billing amounts for out-of-network providers or the cost of non-covered services.

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

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

Deductible is the amount of covered expenses that are paid by a Member per calendar year before benefits are payable by the Plan.

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

Dentally Necessary means services that, in the judgment of Delta Dental:

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

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

Dentist means a licensed dentist, to the extent that they are is operating within the scope of their license as required under law within the state the dentist is practicing.

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

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

Eligible Person means a person who is eligible to receive a benefit under the Plan, as determined by the Group.

Emergency Services means services for a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. Emergency Services include services to treat the following conditions: acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

Group refers to The Nelson Trust, a trust organized for the purpose of providing health and welfare benefits to eligible Members.

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

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

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

In-Network Delta Dental PPO Dentist means a licensed Dentist who contracts in the preferred provider network (PPO) to provide dental care to Members.

In-Network Delta Dental Premier Dentist means a licensed Dentist who contracts in the Premier network to provide dental care to Members.

Limited Exam is an examination of a specific oral health problem or complaint.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a Delta Dental PPO Dentist and for Out-of-Network Dental Providers, the maximum amount is based on the PPO Fee Schedule. For a Delta Dental Premier Dentist, the maximum amount is the Dentist's filed or contracted fee with Delta Dental. When using an Out-of-Network Dental Provider, any amount above the MPA is the Member's responsibility.

Member means a Subscriber or Dependent of a Subscriber who has enrolled for coverage under the terms of the Plan.

Out-of-Network Dental Provider means a licensed Dentist, denturist or hygienist practicing within the scope of their license as required under the law within the state or states in which they practice, who have not entered into a contract with Delta Dental.

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

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

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

Plan Sponsor means the Trust.

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

Posterior refers to teeth located toward the back of the mouth (tooth chart in section 13).

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

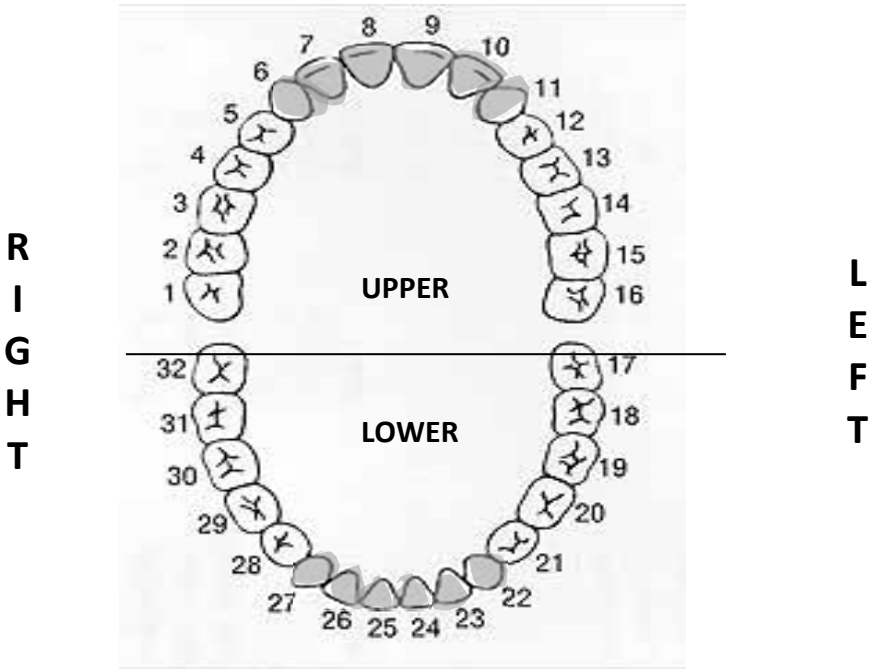
Retainer is a tooth used to support a prosthetic device (implant crowns, Bridges, partial dentures or overdentures).

Subscriber means any Eligible Person who is enrolled in the Plan.

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

SECTION 13. TOOTH CHART

The Permanent Arch



Anterior teeth are shaded gray.

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

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 0569 (8/20)

DELTA DENTAL®

Delta Dental of Oregon & Alaska

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

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

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

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

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

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនសោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

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

P.O. Box 40384
Portland, OR 97240

DeltaORASObk 1-1-2021 (10004450)