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# DENTAL CARE PROGRAM

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**Oregon Steel Mills**

**Dental No. 5027**



Administered by Oregon Dental Service.

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## **BENEFITS PLAN DESCRIPTION**

**The ODS Companies  
601 S.W. Second Avenue  
Portland, Oregon 97204**

### **Telephone Numbers**

#### **Member Inquiries**

**Portland (503) 265-5680  
Toll Free 1-877-277-7280  
TDD/TTY 1-800-433-6313  
(for the hearing and speech impaired)**

#### **Dental Office Inquiries**

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

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

Welcome to Oregon Dental Service (ODS).

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

Oregon Steel Mills reserves the right to amend, modify or terminate the plan in any manner, at any time, which may result in the termination or modification of your coverage. Expenses incurred prior to the plan termination or modification will be paid as provided under the term of the plan prior to termination or modification.

Benefits discussed in this document are effective January 1, 2006.

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

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

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

When you need dental care you may use any dental provider. However, **there are differences in reimbursement by ODS for participating dentists and non-participating dental providers.** An example is provided on page 20. While an eligible person may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

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

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

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

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

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

# Definitions

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

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

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

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

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

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

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

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

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

**Cast restoration** includes crowns, inlays, onlays, and any other restoration to fit a specific patient's

**Claim determination period** means a calendar year (January 1 through December 31) or portion thereof.

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

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

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

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

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

**Deductible** is the amount of covered expenses that are paid by the 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:

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

**Please note:**

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

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

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

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

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

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

**Group eligibility waiting period** means the period of employment or membership with the group that a prospective enrollee must complete before coverage begins.

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

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

**Maximum Plan Allowance** means:

For a participating dental provider, the maximum amount is based on a fee filed with ODS. For non-participating dental providers, the maximum amount is based on a per service average allowance of the participating dentists filed fees. *The non-participating dentist has the right to bill the difference between the ODS Maximum Plan Allowance and the actual charge. This difference will be a patient responsibility.*

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

**Non-participating dental provider** refers to dental providers who have not contracted as ODS Preferred Option Providers or as participating dentists. By using one of these providers, covered dental expenses will be paid at the Out-of-Network rate shown in the Amount of Payment section. Non-participating dental providers are reimbursed at the lesser of the Prevailing Fee and the dental provider's actual billed fees and are subject to patient deductible and coinsurance.

**Non-participating dentist** means a dentist who is neither an ODS Preferred Option provider nor a participating dentist.

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

**ODS Preferred Option Provider** means the dental Preferred Provider Organization (PPO) selected by Policyholder. ODS Preferred Option Providers are dentists who contract to provide dental care to covered employees and their covered dependents. By using a Preferred Option Provider, covered dental expenses will be paid at the In-Network rate shown in the Amount of Payment section. Payment to Preferred Option Providers will be the lesser of the Preferred Option fee schedule and the dentist's actual billed fees.

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

**Participating dentist** means a licensed dentist who has agreed to render services in accordance with terms and conditions established by ODS and has satisfied ODS that he or she is in compliance with such terms and conditions. Payment will be in full, less patient deductible and coinsurance. Payment to Participating Dentist who are not Preferred Option Providers will be based on the dentist's accepted filed fee with ODS and paid at the Out-of-Network rate shown in the Amount of Payment section. The accepted filed fee is the fee the Participating Dentist has agreed to accept as payment in full.

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

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

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

**Plan sponsor** is Oregon Steel Mills who has contracted with Oregon Dental Service to provide claims and other administrative services.

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

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

**Policy year** means the 12-month period commencing on the effective date and each 12-month period thereafter.

**Policyholder** means the group or employer for whose members or employees dental benefits are being provided.

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

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

**Preferred Option Fee Schedule** means the amount negotiated between ODS and the ODS Preferred Option Provider. Payment will be in full, less patient deductible and coinsurance.

**Prevailing fee** in Oregon, means the fee for a single procedure which satisfied the majority (equivalent to the fifty-first (51st) percentile) of dentists in Oregon, as determined by ODS based upon a confidential fee listing accepted by ODS from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

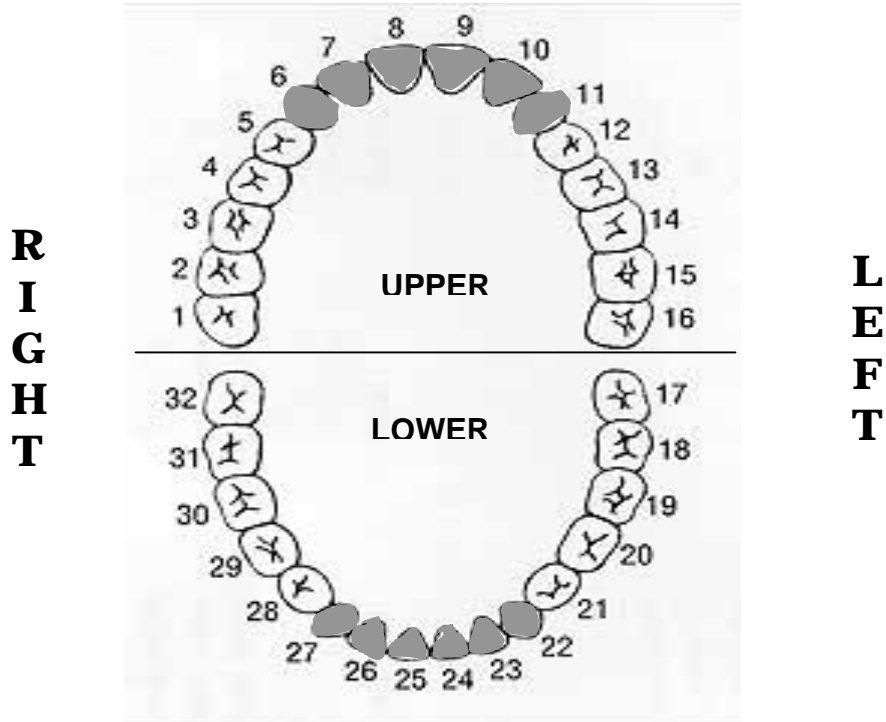
**Prophylaxis** is cleaning and polishing of all teeth.

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

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

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

## Tooth Chart – The Permanent Arch



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

# Eligibility

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This section describes who is eligible to enroll under the Plan. Please be aware that the date you become eligible may be different than the date coverage begins. See "When Coverage Begins" for more specific information. This is located in the "Enrollment" section beginning on page 12.

## EMPLOYEES

You are eligible to enroll in this plan on the first day of the month following your date of full-time employment with Oregon Steel Mills (regularly scheduled to work a minimum of 20 hours per week). You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993.

## DEPENDENTS

If you are married, your legal spouse is eligible for coverage. Your unmarried children are eligible until their 23rd birthday and rely on you for primary support and maintenance. Your unmarried dependent children will continue to be eligible until their 25th birthday, if enrolled as a full-time student at an accredited college, university or vocational school. Children eligible due to a court or administrative order are also subject to the plan's child age limits.

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

- Your natural child;
- Your spouse's child or adopted child;
- Children placed for adoption with you;
- Children related to you by blood or marriage for whom you are the legal guardian. You will need to provide a court order showing legal guardianship.

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

Dependents in military service are *not* eligible.

### **Qualified Medical Child Support Order (QMCSO)**

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

The effective date of coverage for a child added to the plan due to a QMCSO is the date of the court order or the date specified in the court order. If you are not enrolled for coverage, you will be required to enroll along with the child and your share of the cost will be withheld from your pay.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Administrator without charge.

### **NEW DEPENDENTS**

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

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

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

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

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

# Enrollment

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This section explains how to enroll under the Plan.

## **WHEN YOU FIRST BECOME ELIGIBLE**

You must file a complete and signed application for yourself and any dependents you want covered within 31 days of when you become eligible to apply for coverage. File the application with your employer.

You must notify your employer whenever you change your address.

## **WHO PAYS FOR YOUR BENEFITS**

Oregon Steel Mills shares the cost of providing benefits for you and your dependents. From time to time, Oregon Steel Mills may adjust the amount of contributions required for coverage and will inform you of any contribution changes during the open enrollment period. You will be notified of any changes in the cost of plan coverage before they take effect.

## **ENROLLING NEW DEPENDENTS**

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

Even if it does not affect your premium, we must be notified if family members are added or dropped from coverage.

## **OPEN ENROLLMENT FOR LATE ENROLLEES**

If you do not enroll yourself and/or your eligible dependents within 31 days of first becoming eligible, you will be considered a "late enrollee" and will have to wait for the next Open Enrollment period to enroll. Open Enrollment occurs once a year effective January 1.

## **WHEN COVERAGE BEGINS**

Coverage begins for you and any enrolled dependents on the first day of the month following the month in which you are hired or date of full-time employment. If your date of hire is the first day of the month, your coverage begins the first day of the month following the month in which you are hired. If your date of hire is after the first day of the month, your coverage begins the first day of the month following the month in which you are hired.

When a new dependent is due to marriage, coverage begins the first day of the month if the marriage date is the first day of the month. If the marriage did not occur on the first day of the month, coverage begins the first day of the month following the date of marriage.

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

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

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

## **WHEN COVERAGE ENDS**

### **A. Termination By Covered Employee**

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

### **B. Death**

If you die, coverage for your covered dependents ends on the last day of the month in which your death occurs. Note that your covered dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see page 33 for details). The Group must notify us of any continuation of coverage and appropriate premiums must be paid along with the Group's regular monthly payment.

### **C. Termination of Employment**

If your employment terminates, your coverage will end for you and all covered dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 33).

### **D. Loss Of Eligibility By Dependent**

A covered child will lose eligibility when he or she marries, reaches age 23 (25 if full-time student at an accredited college, university or vocational school), is no longer dependent on the eligible employee, or when the eligible employee is no longer legally required to provide coverage for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 33).

Coverage ends for a covered spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under this Plan (see page 33).

**Important Note: The following sections on Family Medical Leave, Leave of Absence and Uniformed Services Employment and Reemployment Rights Act (USERRA) may or may not apply to you. Please check with your company's benefits manager to find out whether or not you qualify for this coverage.**

### **E. Family and Medical Leave**

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

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

### **F. Leave of Absence**

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

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

#### **G. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

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

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

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

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

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

## **H. Other**

See "Continuation of Coverage" section starting on page 33.

### **REINSTATEMENT OF COVERAGE**

If you terminate employment because of a layoff or are rehired within the same calendar year, coverage may be reinstated on the date of rehire if the enrollment requirements are completed within 31 days. All accumulated annual and *lifetime* maximums will apply.

# Preferred Option Plan

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## IN NETWORK BENEFITS - PPO DENTISTS

The following is an outline of the Payment Schedule:

- 1. 100% payment of the Preferred Option Provider's charge (\$2,000.00 Maximum Applies)**
  - (a) Routine oral examination (Twice in a twelve (12) month period);
  - (b) Prophylaxis (Twice in a twelve (12) month period);
  - (c) Fluoride Treatment;
  - (d) Space Maintainers for children under 19 years of age;
  - (e) Emergency Treatment for temporary relief of pain which does not effect a definite cure;
  - (f) General Anesthesia and Intravenous Sedation; and
  - (g) Initial oral examination to plan for orthodontic treatment.
  - (h) Complete mouth x-rays and/or panorex (Once in any three (3) year period); and
  - (i) Supplementary bitewing x-rays (Twice in a twelve (12) month period).
  
- 2. 90% Payment of the Preferred Option Provider's charge.**
  - (a) Benefits for Covered Dental Expenses incurred for correction of damage caused by an accident occurring while covered under the Plan, except those service listed in 1. above. (No Maximum Applies);
  - (b) Repairs to bridge work or dentures, and relining or rebasing of dentures. (\$2,000.00 Maximum Applies); and
  - (c) All covered services, except as listed in paragraphs 1. and 3. of the Appendix. (\$2,000.00 Maximum Applies)
  
- 3. 60% Payment of the Preferred Option Provider's charge (\$2,000.00 Maximum Applies)**
  - (a) All Prosthodontic Benefits **except** those stated in 2. above.

**Maximum Payment** The maximum amount payable by the program for covered services received each calendar year, or portion thereof, for each eligible patient is limited to \$2,000.00

**Deductible** covered dental services listed in paragraphs 2. and 3. above are subject to a \$50.00 deductible per patient, not to exceed \$150.00 for the entire family, each calendar or portion thereof.

Payment to an ODS Preferred Option Provider will be the lesser of the Preferred Option fee schedule and the dentists actual billed fees.

## **OUT-OF-NETWORK BENEFITS - NON-PPO and NON- Participating DENTISTS**

The following is an outline of the Payment Schedule:

### **1. 100% payment (\$2,000.00 Maximum Applies)**

- (a) Routine oral examination (Twice in a twelve (12) month period);
- (b) Prophylaxis (Twice in a twelve (12) month period);
- (c) Fluoride Treatment;
- (d) Space Maintainers for children under 19 years of age;
- (e) Emergency Treatment for temporary relief of pain which does not effect a definite cure;
- (f) General Anesthesia and Intravenous Sedation; and
- (g) Initial oral examination to plan for orthodontic treatment.
- (h) Complete mouth x-rays and/or panorex (Once in any three (3) year period); and
- (i) Supplementary bitewing x-rays (Two every twelve (12) months).

### **2. 85% Payment**

- (a) Benefits for Covered Dental Expenses incurred for correction of damage caused by an accident occurring while covered under the Plan, except those service listed in 1. above. (No Maximum Applies);
- (b) Repairs to bridge work or dentures, and relining or rebasing of dentures. (\$2,000.00 Maximum Applies); and
- (c) All covered services, except as listed in paragraphs 1. and 3. of the Appendix. (\$2,000.00 Maximum Applies)

### **3. 50% Payment (\$2,000.00 Maximum Applies)**

- (a) All Prosthodontic Benefits **except** those stated in 2. above.

**Maximum Payment** The maximum amount payable by the program for covered services received each calendar year, or portion thereof, for each eligible patient is limited to \$2,000.00

**Deductible** covered dental services listed in paragraphs 2. and 3. above are subject to a \$50.00 deductible per patient, not to exceed \$150.00 for the entire family, each calendar or portion thereof.

### **Participating Dentists Who are not PPO Dentists**

Payment to Participating Dentists who are not ODS Preferred Option Providers will be based on the dentist's accepted filed fee or fees actually charged, whichever is less.

## **Non-Participating Dental Providers**

Payment to a non-participating dental provider is limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

## Example of how the Plan works

Total Charge	\$800.00
In-Network Benefit	90%
Out of Network Benefit	85%

Please note the payments on specific claims will be based on the individual agreement between ODS and the providers. For purposes of this example, it is assumed any applicable deductible has been met.

### Example:

<b>When care is provided by an ODS Preferred Option Provider</b>	
Preferred Option Provider total charges	\$800.00
Preferred Option fee Schedule; the amount negotiated between ODS and the ODS Preferred Option Provider	\$585.00
Plan pays 90%	\$526.50
You pay 10%	\$58.50
<b>TOTAL AMOUNT YOU WOULD PAY</b>	<b>\$58.50</b>
<b>When care is provided by a Participating Dentist, but not an ODS Preferred Option Provider</b>	
Participating Dentist total charges	\$800.00
Participating Dentist accepted fee; the fee the Participating Provider has agreed to accept as payment in full.	\$700.00
Plan pays 85%	\$595.00
You pay 15%	\$105.00
<b>TOTAL AMOUNT YOU WOULD PAY</b>	<b>\$105.00</b>
The additional amount you would pay for using a Participating Dentist who is not an ODS Preferred Option Provider	<b>\$46.50</b>
<b>When care is provided by a Non-Participating Dentist</b>	
Non-Participating Dentist total charge	\$800.00
Maximum Plan Allowance as calculated by ODS	\$670.00
Plan pays 85%	\$569.50
You pay 15%	\$100.50
You pay difference between total charges and Maximum Plan Allowance	\$130.00
<b>TOTAL AMOUNT YOU WOULD PAY</b>	<b>\$230.50</b>
The additional amount you would pay for using a Non-Participating Dentist is	<b>\$172.00</b>

# Benefits and Limitations

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Below is a general list of services your dental care program covers when performed by a licensed dentist, certified denturist or registered hygienist to the extent that he or she is operating within the scope of his or her license, certificate or registration as required under law in the State of practice. These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical) including masticatory (chewing) function. A panel of dentists shall determine these standards.

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

**Limitations may apply to these services, please see below. Also, see page 27 for exclusions.**

## I. Class I

### A. Diagnostic

#### Examination

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

#### *Diagnostic Limitations:*

1. Periodic (routine) or comprehensive examinations or consultations are covered only twice per twelve (12) month period.
2. Complete series x-rays or a panoramic film is covered only once in any three (3) year period.
3. Supplementary bitewing x-rays are covered only twice per twelve (12) month period.
4. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
5. Only the following x-rays are covered by the plan: complete series or panoramic, periapical, occlusal, and bitewings.
6. Initial oral examination to plan for orthodontic treatment

**B. Preventive**

Prophylaxis (Cleanings)  
Topical application of fluoride  
Space maintainers  
Sealants

***Preventive Limitations:***

1. Prophylaxis (cleaning) or periodontal maintenance is covered only twice per twelve (12) month period.
2. Topical application of fluoride is covered only twice per twelve (12) month period year for all ages.
3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspid and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.
4. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for patients age 19 or over are not covered.

**C. Miscellaneous**

Emergency treatment

***Miscellaneous Limitations:***

1. Emergency treatment for temporary relief of pain which does not effect a definite cure.

**II. Class II**

**A. Restorative**

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

***Restorative Limitations:***

1. Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. **If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.**
2. Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
3. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.

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

**B. Oral Surgery**

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

***Oral Surgery Limitations:***

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

**C. Endodontic**

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

***Endodontic Limitations:***

1. A separate charge for cultures is not covered.
2. Pulp capping is covered only when there is exposure of the pulp.
3. Retreatment by the same dentist within 24 months of a root canal is considered inclusive of the root canal cost and is not a benefit.

**D. Periodontic**

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

***Periodontic Limitations:***

1. Periodontal scaling and root planning is limited to once per quadrant in any twenty-four (24) month period.
2. Coverage for periodontal maintenance procedure or prophylaxis (cleaning) is limited to twice in a twelve (12) month period.
3. A separate charge for post-operative care done within three (3) months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a three (3) year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within twenty-four (24) months.

**E. Intravenous Sedation and General Anesthesia**

Intravenous sedation and general anesthesia are covered when administered for a covered oral or dental surgery procedure performed by a dentist, or when administered to relax or calm patients handicapped by severe mental or physical disorders who are having covered dental procedures performed by a dentist.

**III. Class III**

**A. Restorative**

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

***Restorative Limitations:***

1. Cast restorations (including pontics) are covered once in a five (5) year period on any tooth. See Class II for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

**B. Prosthodontic**

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

***Prosthodontic Limitations:***

1. A prosthetic device or crown will be covered only once in a five (5) year period provided the tooth has not been crowned within the past five (5) years.
2. A bridge or partial is not covered if the tooth received a cast restoration benefit within the previous five (5) years.
3. *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.

4. *Partial dentures:* A temporary (interim) partial is only a benefit when placed within two (2) months of a recently extracted anterior tooth or for missing anterior permanent teeth of patients age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to carious lesions (decay) or broken teeth.
5. *Denture adjustments and relines:* A separate, additional charge for denture adjustments and relines done within six (6) months after the initial placement is not covered. Subsequent relines will be covered only once per denture in a twelve (12) month period. Subsequent adjustments are limited to two (2) adjustments per denture in a twelve (12) month period.
6. Tissue conditioning is covered no more than twice per denture in a 36-month period.
7. Surgical placement, removal of implants, or related services are not covered. We will benefit:
  - The final crown and abutment over a single implant. This benefit is limited to once per tooth in any five-year period; or
  - Provide an alternate benefit per arch of a full or partial denture for the final prosthetic when the implant is placed to support a prosthetic device. The alternate benefit will apply to the frequency limitation (only once in any five-year period) for prosthetic devices.
  - This benefit or alternate benefit is not provided if the tooth received a cast restoration benefit within the previous five (5) years.
8. Fixed bridges or removable cast partials are not covered for patients under age sixteen (16).
9. Porcelain prosthetics to replace posterior (back) teeth are considered optional. Coverage shall be made for a corresponding metallic prosthetic. You will have additional patient responsibility for tooth colored prosthetics placed on back teeth.

# Orthodontic Benefit

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Orthodontic services are a benefit for you and your covered dependents.

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

The Plan will pay **50%** of the participating orthodontist's charge for orthodontic services, up to the maximum benefit. The amount payable to a non-participating orthodontist will be the lesser of 50% of the orthodontist's fees or 50% of the median fee of all participating orthodontists' filed fees with ODS.

**The maximum amount the Plan will pay for orthodontic services for a covered patient is \$2,000.00. This maximum is not included in the dental policy maximum.**

**If the dental policy has a deductible, it does not apply to orthodontic services.**

## LIMITATIONS

1. The obligation of the Plan to make payments for treatment will cease upon termination of treatment for any reason prior to completion.
2. The Plan will not make payment for repair or replacement of an appliance furnished under this program.
3. The obligation of the Plan to make payments for treatment shall cease on termination of eligibility or of this Policy.
4. If treatment began before the patient was eligible under this Policy, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

# Exclusions

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1. Procedures, appliances, restorations or other services which are primarily for cosmetic purposes.
2. The plan does not cover:
  - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this plan;
  - Services that are inappropriate with regard to standards of good dental practice;
  - Services with poor prognosis.
3. The following are not covered:
  - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
  - Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
  - Services which are provided, without cost to the eligible person, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Policy; or
  - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, are excluded.
4. Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).
5. A separate charge for periodontal charting is not covered.
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

7. Services or supplies for treatment of any disturbance of the temporomandibular joint.
8. Gnathologic recordings or similar procedures.
9. Dental services started prior to the date the individual became eligible for such services under the Policy.
10. Hypnosis, premedications, analgesics (e.g. nitrous oxide), anesthetics, or any other prescribed drugs are excluded.
11. Hospital charges for services or supplies or additional fees charged by the dental provider for hospital treatment.
12. Charges for missed or broken appointments.
13. Experimental procedures or supplies.
14. Services rendered or supplies furnished after the date the patient ceases to be eligible hereunder, except for Class III services which were ordered and fitted prior to such date and then only if such items are placed within thirty-one (31) days after such termination of eligibility.
15. General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or as covered by Class II Services, paragraph E. on page 24.
16. Surgical placement or removal of implants is not covered.
17. Plaque control and oral hygiene or dietary instruction are not covered.
18. Claims submitted more than 15 months after the date of rendition of the service.
19. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.
20. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.
21. Taxes.

## Coordination of Benefits (COB)

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This provision applies to this Plan when you or your covered dependent have healthcare coverage under more than one Plan. 'Plan' and 'This Plan' are defined below:

### DEFINITIONS

**Plan** means any of the following coverages, including Plan coverage, which provide benefit payments or services to a covered person for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trustees plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group coverage.

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

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

**Claimant** means the covered person for whom the claim is made.

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

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

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

**This Plan** is the part of the group contract that provides benefits for healthcare expenses.

## HOW COB WORKS

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

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

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

## WHICH PLAN PAYS FIRST?

When another Plan does not have a COB provision, that Plan must determine benefits first. When another Plan does have a COB provision, the first of the following rules that applies will govern:

- **Non-dependent/Dependent.** If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will determine its benefits before a Plan which covers the person as a dependent.
- **Dependent Child/Parents Not Separated or Divorced.** If the claimant is a dependent child whose parents are not divorced or separated then the Plan of the parent whose birthday falls earlier in the calendar year will determine its benefits before those of the Plan of the parent whose birthday falls later in that year. If both parents' birthdays are on the same day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
- **Dependent Child/Separated or Divorced Parents.** If two or more plans cover the claimant as a dependent child of divorced or separated parents, then the following rules apply:
  - First the Plan of the parent with custody of the child, then the Plan of the spouse of the parent with custody of the child, and finally the Plan of the parent without custody.

- However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or non-dependent longer are determined before those of the plan which covered that person for the shorter time.

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

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

## **CREDIT SAVINGS**

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

## **COB AND PLAN LIMITS**

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

## **THE PLAN'S RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION**

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

## **FACILITY OF PAYMENT**

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

## **RIGHT OF RECOVERY**

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

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

## **CORRECTION OF PAYMENTS**

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

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

# **Continuation of Coverage**

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## **Continuation Coverage Under Federal Law (COBRA)**

As mandated by federal law (COBRA), the plan offers optional continuation coverage to you and/or your dependents if coverage would otherwise end due to certain events. Refer to the Oregon Steel Mills Employee Benefits Plan Summary Plan Description for complete information regarding your COBRA right.

### **Individual Dental Exchange Program**

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

### **TRADE ACT OF 2002**

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

#### **A. Second Election Period for Certain Trade-Displaced Individuals**

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

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

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

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

#### **B. Duration of COBRA Coverage Elected During the Special Second Election Period**

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

#### **C. COBRA Tax Credit**

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

# Claims Administration and Payment

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The following section explains how claims are administered.

## SUBMISSION AND PAYMENT OF CLAIMS

### A. Claim Submission

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than one year from the date submission is otherwise required.

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

### B. Explanation of Benefits (EOB)

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

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

### C. Claim Inquiries

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

### D. Plan Time Frames for Processing Claims

If your claim is denied, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information to complete our processing of

your claim, our notice of delay will describe the information needed and the party responsible for providing the additional information will have at least 45 days to submit the additional information. Once we receive the additional information, we will complete our processing of the claim within 30 days.

## APPEALS

### A. Definitions

For purposes of this section, the following definitions apply:

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

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

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

**Post-service claim** means any claim for a benefit under a group health plan that is not a pre-service claim.

**Pre-service claim** 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 “**claim involving urgent care**” means any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- (A) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or,
- (B) In the opinion of a dentist with knowledge of the enrollee’s dental condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

#### **B. Time Limit for Submitting Appeals**

You have **180 days** from the date of an adverse benefit determination to submit a written appeal regarding an adverse determination. If a written appeal is not submitted within the appropriate timeframes as outlined in this section, you will lose your rights to the appeals process. If you do not submit your written appeal on time, you may lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

#### **C. The Review Process**

The Plan has a two-level review process. The first level of review is called a First Level Appeal. The second level of review is a Second Level Appeal. You must exhaust these two levels of review before you can exercise your right to file a lawsuit in court under ERISA Section 502(a).

#### **Note:**

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

- The time period is too long to accommodate the clinical urgency of the situation;
- The enrollee does not reasonably cooperate; or
- Circumstances beyond the control of either party prevents that party from complying with the standards set but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

#### **D. First Level Appeals**

You may request that ODS review an adverse benefit determination. Your request, called an appeal, must be in writing. If you need assistance on filing an appeal, contact ODS Dental Customer Service Department at (503) 265-5680 or toll-free at 1-877-277-7280 to discuss the issue as it may be possible to resolve your situation with a phone call. You may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request, and free of

charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. ODS' response time to your appeal is based on the nature of the claim. The appeal will receive a full investigation by persons who were not involved in the initial determination.

An appeal related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. An appeal related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the appeal by the plan, unless the enrollee fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, ODS shall notify the enrollee as soon as possible, but no later than 24 hours after receipt of the appeal by the plan, of the specific information necessary to complete the claim. The enrollee shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. ODS shall notify the enrollee of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the plan's receipt of the specified information, or (b) the end of the period afforded the enrollee to provide the specified additional information.

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

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

When an investigation has been completed, you will receive a written notice of the disposition of your appeal, including the basis for the decision, along with information on your right to a Second Level Appeal.

#### **E. Second Level Appeal**

If you disagree with our decision made in response to a First Level Appeal, you may request a review of the decision. Your second appeal must be made within 60 days of the date of our action on your initial appeal. You may also call our Dental Customer Service Department at (503) 265-5680 or toll-free at 1-877-277-7280 to discuss the issue as it may be possible to resolve it without filing a second appeal.

If you request a Second Level Appeal, you must submit your appeal in writing. Your Second Level Appeal will be reviewed by persons who were not previously involved in the review of the First Level Appeal. You have the option to appear before the panel in person or by conference call or other appropriate technology. ODS will allow your representative to act on your behalf in the appeal process if you choose.

A Second Level Appeal of an **urgent care claim** is subject to expedited review and time provisions described above with respect to appeals related to an **urgent care claim**. Investigations and responses to your appeal will follow the same timelines outlined under the First Level Appeal subsection. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. You may expect a written notice of the disposition of your appeal, including the basis for the decision, along with information on your right to file suit under ERISA 502(a).

## **BENEFITS AVAILABLE FROM OTHER SOURCES**

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

### **A. Coordination of Benefits (COB)**

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

### **B. Third Party Liability**

An individual covered by us may have a legal right to recover benefit or healthcare costs from another person, organization or entity or an insurer, as a result of an illness or injury for which benefits or healthcare costs were paid by us. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the illness or injury. Should we make an advance payment of Benefits, as described below, we are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by us through these recoveries help reduce the cost of premiums and providing benefits.

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

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

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

**Definitions:**

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

1. "Covered Individual" means an individual covered by us, including a dependent of a Member. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or dental/medical expenses of such individual.
2. "Benefits" means any amount paid by us, or submitted to us for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of "Benefits" by the Covered Individual.
3. "Third Party Claim" means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of dental/medical expenses from us, may file a Third Party claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover Benefits as described herein.)

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

Under this Section relating to Third Party Recoveries, if we have paid any benefits, we will be entitled to recover the amount we have paid from the proceeds of any recovery made by a Covered Individual against a Third Party. Upon claiming benefits, or accepting payment of benefits, or claiming or accepting the provision of benefits from us, the Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. In connection with our rights to obtain reimbursement or exercise our rights as described below, the Covered Individual shall do one or more of the following things and agrees that we may do one or more of the following things, at our discretion:

- a. If the Covered Individual seeks payment by us of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a Provider to the Covered Individual.
- b. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us from the Third Party.
- c. In order to receive an advance payment of Benefits pursuant to this Section, we require that any Covered Individual seeking payment of Benefits by us, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Person's parent or guardian, must fill out, sign and return to our office a Third-Party Recovery Agreement that includes a questionnaire about the accident and the potential Third-Party recovery. This Agreement will include provisions consistent with the provisions of this Section, including an agreement to repay us for any benefits that we have paid

relating to the injuries for which the Covered Individual is seeking recovery from a Third Party. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.

- d. If the Covered Individual makes a demand upon a Third Party, enters into settlement negotiations or commences litigation, the Covered Individual must not prejudice, in any way, our recovery rights under this Section. If a suit is filed by the Covered Individual, the Covered Individual agrees that we may cause to be recorded a notice of payment of Benefits, and such notice will constitute a lien on any judgment or settlement. We may provide notice to the Third Party or its insurer. In the event of settlement, the Covered Individual must obtain our consent prior to releasing any Third Party from liability for payment of any expenses covered, paid or pending for payment by us. The Covered Individual will hold the rights of and to Recovery Funds in trust for our benefit, up to the amount of Benefits we have paid or which are pending payment at the time of resolution of the Third Party Claim.
- e. For any Benefits paid by us or pending payment by us, the Covered Individual shall promptly reimburse us from any Recovery Funds, the full value of any such Benefits paid, provided, or which are pending for payment by us.
- f. To secure our rights to reimbursement for any Benefits paid or provided, the Covered Individual, by claiming or accepting payment or the provision of Benefits by us hereby grants to us a first priority lien against the proceeds of any Third Party Claim and assigns to us any benefits the Covered Individual may have under any insurance coverages, such lien and assignment to apply only to the extent of Benefits paid, provided, or pending for payment.
- g. The Covered Individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:
  - i. Sign and deliver such documents as we reasonably require to protect our rights;
  - ii. Provide any information to us relevant to the application of the provisions of this Section, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
  - iii. Take such actions as we may reasonably request to assist us in enforcing our rights to be reimbursed from Third Party recoveries.

- h. We will pay our proportionate share of attorney fees for obtaining Recovery Funds in a Third Party Claim out of any part of the Recovery Funds which are reimbursed to us by the Covered Individual; otherwise, we have no obligation to pay attorney's fees or costs with respect to litigation to recover Benefits in a Third Party Claim initiated or controlled by the Covered Individual.**
- i. By accepting the payment of benefits by us, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party. If we choose to intervene in the Third Party Claim, we shall not be liable for any attorney fees or costs incurred by the Covered Individual in connection with the Third Party Claim, including pursuant to subparagraph h. above, and we shall have no obligation to reimburse the Covered Individual for such attorneys fees or costs.**
- j. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.**
- k. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out reimbursement from Third Party recoveries and the provisions of this Section.**
- l. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.**
- m. If the Covered Individual continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we will provide Benefits for the continuing treatment of that illness or injury pursuant to the terms of this Third Party Claims Section and only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing dental/medical treatment have been exhausted for that purpose.**
- n. By accepting Benefits, paid or on behalf of the Covered Individual, the Covered Individual agrees with the provisions of this Section and instructs his/her legal representatives to comply with the provisions of this Section.**

- o. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or dental/medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify dental/medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.
- p. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.
- q. Coordination of Benefits (where the Covered Individual has healthcare coverage under more than one Plan or health insurance policy) is not considered a Third Party Claim.
- r. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

### **C. Motor Vehicle Insurance**

We will not pay benefits for healthcare costs to the extent that a Covered Individual including a covered dependent, is covered by motor vehicle insurance. But we will advance payment of Benefits over the amount covered by the motor vehicle insurance, subject to the Third Party Recovery Section above. If we have paid Benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the Third Party Recovery Section above.

You must give us information about any dental insurance payments available to the Covered Individual or the Covered Individual's covered dependents.

# **General Plan Information**

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

## **REQUEST FOR INFORMATION**

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

## **DISCLOSURE OF BENEFIT REDUCTION**

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

## **CONFIDENTIALITY OF MEMBER INFORMATION**

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

## **TRANSFER OF BENEFITS**

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

## **RECOVERY OF BENEFITS PAID BY MISTAKE**

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

## **CONTRACT PROVISIONS**

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

## **WARRANTIES**

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

## **LIMITATION OF LIABILITY**

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

## **PROVIDER REIMBURSEMENTS**

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

## **INDEPENDENT CONTRACTOR DISCLAIMER**

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

## **NO WAIVER**

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

## **GROUP IS THE AGENT**

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

## **GOVERNING LAW**

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

## **WHERE ANY LEGAL ACTION MUST BE FILED**

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

## **TIME LIMITS FOR FILING A LAWSUIT**

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

# **General ERISA Information**

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## **General ERISA Information**

Refer to the Oregon Steel Mills Employee Benefits Plan Summary Plan Description for the general plan information required under the Employee Retirement Income Security Act of 1974 (ERISA).

## **ERISA Rights**

As a participant in the Oregon Steel Mills Health Plan, you are entitled to certain rights and protections under the Employee Retirement Security Act of 1974 (ERISA). Refer to the Oregon Steel Mills Employee Benefits Plan Summary Plan Description for the complete Statement of ERISA Rights of Plan Participants.



601 S.W. Second Avenue  
Portland, OR 97204

**Telephone Numbers**

<u>Member Inquiries</u>		<u>Dental Office Inquiries</u>	
Portland	(503) 265-5680	Portland	(503) 243-4494
Toll Free	1-877-277-7280	Toll Free	1-800-452-1058
TDD/TTY	1-800-433-6313		
(for the hearing and speech impaired)			

[www.odscompanies.com](http://www.odscompanies.com)



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