Oregon Individual Dental Policy

Delta Dental PPO Plan

This policy is authorized by the signature of Delta Dental Plan of Oregon's representative.

Scott Loftin
Senior Vice President
601 SW Second Avenue
Portland, OR 97204

The subscriber may return this policy to Delta Dental within 10 days of its delivery and have the premium paid refunded. In such a case, this policy shall then be voided from the beginning and Delta Dental Plan of Oregon will hold the position as if no policy has been issued.

Dental plans in Oregon provided by Delta Dental Plan of Oregon

DeltaORIndv 1-1-2022

Delta Dental renews this individual plan on January 1 each year, including benefit and rate adjustments. Rates may also change on the renewal date if a member has moved into the next age bracket of the rate table. Rates may change when the family composition changes, with new rates effective the first of the following month.

Individual policies and other services are available at www.DeltaDentalOR.com.

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SECTION 1. WELCOME

Delta Dental Plan of Oregon (abbreviated as Delta Dental), was created in 1955 and is a founding member of the Delta Dental Plans Association. Delta Dental Plan of Oregon is the state's largest dental insurer and is pleased to provide individual dental coverage to members through the Delta Dental PPO Plan. This policy is designed to provide members important information about the Plan's benefits, limitations and procedures.

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

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

This policy is a description of members' individual dental coverage. This policy may be changed or replaced without the consent of any member other than the subscriber. The most current policy is available on My Dashboard, accessed through the Delta Dental website. All provisions are governed by this policy between the subscriber and Delta Dental.

This plan provides pediatric dental coverage as required under the Affordable Care Act.

IMPORTANT NOTE: IF CHILD ONLY COVERAGE

If this is a child only plan, all references in this policy to dependents, including a spouse, domestic partner or children, are considered deleted. Siblings of the subscriber are eligible.

Insurance products provided by Delta Dental Plan of Oregon
Portland, Oregon

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

Dental Customer Service Department
Toll-free 844-235-8013
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

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

2.3 NETWORK

See Network Information (section 3.1) for details about how the network works.

Dental network
Delta Dental PPO Network

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 10 and Section 12.

SECTION 3. USING THE PLAN

For questions about the policy, members should contact Customer Service. This policy describes members' dental coverage. It is the member's responsibility to review this policy carefully and to be aware of its limitations and exclusions.

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

3.1 NETWORK INFORMATION

The Delta Dental Plan is easy to use and cost effective. In-network Delta Dental PPO dentists contract to provide dental care to members. By using an in-network Delta Dental PPO dentist, covered dental expenses will be paid at a higher rate. If members choose an in-network dentist from the Delta Dental PPO Directory (which is available on Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. For travelers outside Oregon, Delta Dental's national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Members needing dental care may go to any dental office. However, there are differences in reimbursement by Delta Dental for in-network Delta Dental PPO dentists and out-of-network dentists. Out-of-network dentists include participating Delta Dental Premier (contracted with the Delta Dental Premier network) and non-participating dentists (not contracted with Delta Dental). While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

3.1.1 In-Network Delta Dental Dentists

When using an in-network Delta Dental PPO dentist, covered dental expenses will be paid at the in-network rate. Payment to in-network Delta Dental PPO dentists will be the lesser of the PPO fee schedule amount and the dentist's actual billed fees. The dentist may not charge the member the difference between the PPO fee schedule amount and the billed charge.

3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist participating in the Delta Dental Premier network will be paid at the out-of-network rate, and will be based on the dentist's filed or contracted fee with Delta Dental or fees actually charged, whichever is less. The dentist may not charge the member the difference between the filed fee and the billed charge.

Payment to an out-of-network dentist not participating in a Delta Dental network will be limited to the amount in the PPO fee schedule. The member may have to pay the difference between the PPO fee schedule amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

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

SECTION 4. BENEFITS AND LIMITATIONS

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

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certification or registration.

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

Covered services, when generally accepted dental practices and standards determine they can be safely and effectively provided using teledentistry (audio, video or both), are covered when provided by a provider using such telephone or internet conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information.

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

Coverage of pediatric benefits is provided until the end of the month in which the member turns 19 years of age.

Deductible: $0
Per member per year, or portion thereof

Out-of-Pocket maximum: $375 for one member, $750 for 2 or more members
Per year for members under age 19.
All covered in-network services accrue to the out-of-pocket maximum.
Only covered in-network services accrue to the out-of-pocket maximum. When members use out-of-network dentists, their out-of-pocket expenses do not accrue to the out-of-pocket maximum. Covered services by an out-of-network dentist are always subject to coinsurance

Annual maximum plan payment limit: $1,000
Per member age 19 and over per year, or portion thereof
All covered services (Class I, II, III) apply to the annual maximum plan payment limit.
Members are responsible for expenses that exceed the annual maximum plan payment limit.

4.1 CLASS I

COVERED IN-NETWORK SERVICES PAID AT 100% (OUT-OF-NETWORK AT 60%) FOR MEMBERS UNDER AGE 19

COVERED IN-NETWORK SERVICES PAID AT 75% (OUT-OF-NETWORK AT 50%) FOR MEMBERS AGE 19 AND OVER

4.1.1 Diagnostic

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

b. **Diagnostic Limitations:**
   i. Periodic (routine) or comprehensive examinations (including problem focused comprehensive examinations) or consultations are covered once in any 6-month period
   ii. Limited examinations or re-evaluations are limited to twice per year
   iii. Complete series x-rays or a panoramic film is covered once in any 5-year period
   iv. Supplementary bitewing x-rays are covered once in any 12-month period
   v. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
   vi. Only the following x-rays are covered: complete series or panoramic, periapical, occlusal and bitewing

4.1.2 Preventive

a. **Preventive Services:**
   i. Prophylaxis (cleanings)
   ii. Periodontal maintenance
   iii. Topical application of fluoride
   iv. Interim caries arresting medicament application
   v. Sealants

b. **Preventive Limitations:**
   i. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year.
   ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
   iii. Topical application of fluoride is covered once in any 6-month period for members under age 19. For members age 19 and over, topical application of fluoride is covered once in any 12-month period if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).

iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealant benefits are limited to the unrestored occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period, except for evidence of clinical failure.

*Members under age 19 who have high risk oral conditions due to disease process, pregnancy, medications or other medical treatment or conditions, severe periodontal disease, rampant tooth decay and/or who have disabilities that prevent them from performing adequate daily oral healthcare are eligible for additional cleanings or fluoride when dentally necessary.

Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see Section 5).

4.2 CLASS II

COVERED IN-NETWORK SERVICES PAID AT 25% (OUT-OF-NETWORK AT 25%) FOR MEMBERS UNDER AGE 19

COVERED IN-NETWORK SERVICES PAID AT 60% (OUT-OF-NETWORK AT 50%) FOR MEMBERS AGE 19 AND OVER

There is a 6-month exclusion period for Class II services. The exclusion period will be waived if the member is under age 19 or had prior coverage (see section 4.4).

4.2.1 Preventive

a. **Preventive Services:**
   i. Space maintainers

b. **Preventive Limitations:**
   i. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 19 or over are not covered.

4.2.2 Restorative

a. **Restorative Services:**
   i. Amalgam and composite fillings for the treatment of decay.
   ii. Stainless steel crowns

b. **Restorative Limitations:**
   i. Restorations are not covered within 3 months of interim caries arresting medicament application for members age 19 and over.

ii. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided.
iii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains.
v. Replacement of a stainless steel crown by the same dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.
vi. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.3.4.

4.3 CLASS III

COVERED IN-NETWORK SERVICES PAID AT 25% (OUT-OF-NETWORK AT 25%) FOR MEMBERS UNDER AGE 19

COVERED IN-NETWORK SERVICES PAID AT 50% (OUT-OF-NETWORK AT 50%) FOR MEMBERS AGE 19 AND OVER

There is a 12-month exclusion period for Class III services. The exclusion period will be waived if the member is under age 19 or had prior coverage (see section 4.4).

4.3.1 Oral Surgery

a. **Oral Surgery Services:**
   i. Extractions (including surgical)
   ii. Other minor surgical procedures

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

4.3.2 Endodontic

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

b. **Endodontic Limitations:**
   i. A separate charge for cultures is not covered.
   ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
   iii. A separate charge for pulp capping is not covered.
   iv. Retreatment of symptomatic anterior teeth is covered for members under age 19. Retreatment of bicuspid and posterior teeth, and anterior teeth for members age 19 and over, by the same dentist within 2 years of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.
   v. A subsequent retrograde filling by the same dentist within a 2-year period of an initial retrograde filling is not covered.

4.3.3 Periodontic

a. **Periodontic Services:**
   i. Treatment of diseases of the gums and supporting structures of the teeth.

b. **Periodontic Limitations:**
   i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
   ii. Periodontal maintenance is covered under Class I, Preventive.
   iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
   iv. Osseous surgery is limited to a maximum of 2 quadrants per visit.
   v. Bone replacement grafts are covered once per quadrant in a 3-year period.
   vi. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of the initial periodontal surgery are not covered for members age 19 and over.
   vii. Full mouth debridement is limited to once in a 2-year period and, if the member is 19 or over, only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months. (Variable: delete if plan is pediatric only).

4.3.4 Restorative

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

b. **Restorative Limitations:**
   i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 4.2.2 for limitations on buildups.
   ii. Cast restorations are not eligible for coverage within 3 months of interim caries arresting medicament application. Repair of a cast restoration within 2 years of the original cast restoration is not eligible for additional coverage. These limitations do not apply to anterior crowns and the repair of anterior crowns for members under age 19.

iii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iv. If a tooth can be restored with a material such as composite, but another type of restoration is selected, covered expense will be limited to the cost of composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.
v. Re-cement or re-bond of a crown, inlay, onlay or veneer, by the same dentist, is limited to once per lifetime.

4.3.5 Prosthodontic

a. **Prosthodontic Services:**
   i. Bridges for members age 19 and over
   ii. Partial and complete dentures
   iii. Denture relines
   iv. Repair of an existing prosthetic device
   v. Surgical stent in conjunction with a covered surgical procedure

b. **Prosthodontic Limitations:**
   i. A bridge or a full or partial denture will be covered once in a 7-year period and only if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last 7 years.
   ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
   iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
   iv. Denture adjustments, repairs and relines: A separate, additional charge for denture adjustments, repairs and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period for members age 19 and over.
   v. Denture rebase is covered only if a reline may not adequately solve the problem. A rebase is limited to once in a 12-month period.
   vi. Tissue conditioning is covered no more than twice per denture in a 36-month period.
   vii. Dentures are not covered for members under age 16.
   viii. Surgical placement or removal of implants, or related services, are not covered. The Plan will cover:

A. The final crown and abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant
B. 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
C. This benefit or alternate benefit is not provided if the tooth received a cast restoration or prosthodontic benefit within the previous 7 years.

ix. The re-cement or re-bond of an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.
x. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.
xi. Prosthodontics are not covered within 3 months of interim caries arresting medicament application. This limitation does not apply to dentures for members under age 19.

4.3.6 Other

a. General anesthesia or IV sedation
Covered only:
i. In conjunction with covered surgical procedures performed in a dental office
ii. When necessary due to concurrent medical conditions

b. Oral anesthesia medication
Covered only:
i. For members under age 19
ii. When used during an in-office procedure

c. Orthodontia
i. Orthodontia and placement of a device to facilitate eruption of an impacted tooth are covered only when necessary to treat cleft palate with or without cleft lip for members under age 19.

d. Athletic mouthguard
i. Covered once in any 12-month period for members under age 16 and once in any 2-year period age 16 and over. These time periods are calculated from the previous date of service.
ii. Over the counter mouthguards are not covered

e. Night guard (Occlusal Guard)
i. Covered once in any 5-year period at 100%, up to $150 maximum with no deductible. Members are responsible for any amount above the $150 maximum.
ii. Repair or reline of occlusal guard is covered once every 12-month period. One occlusal guard adjustment is covered every 12-month period.
iii. Over the counter occlusal guards are not covered

f. Translation and Sign Language Services

i. Translation or sign language service is included in the fees for overall patient management and is not covered as a separate benefit.

4.4 EXCLUSION PERIOD AND CREDITABLE COVERAGE

Class II services are subject to a 6-month exclusion period and Class III services are subject to a 12-month exclusion period. The exclusion period will be waived if the member is under age 19 or provides evidence of 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the effective date of this Policy. To qualify, the previous plan must have provided coverage for standard dental services as determined by Delta Dental.

4.5 GENERAL LIMITATION - OPTIONAL SERVICES

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

SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy. Studies have shown a relationship between periodontal disease, bacteria in the mouth and various health problems including pre-term, low birth weight babies and diabetes. Delta Dental has developed a program that provides additional cleanings (prophylaxis and periodontal maintenance) for Delta Dental members based on this evidence.

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

This benefit is for the cleaning only. Coverage for a routine exam and other services are subject to the frequency limitations outlined in Section 4.

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

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

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

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

5.2 HOW TO ENROLL

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

SECTION 6. EXCLUSIONS

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

Analgesics
Substances used for the purpose of pain relief

Anesthesia or Sedation
Local anesthetics, nitrous oxide for members over age 19, general anesthesia and IV sedation except as stated in section 4.3.6

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

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

Congenital or Developmental Malformations
Including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth). Except orthodontia for treatment of cleft palate may be covered for members under age 19.

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

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

Duplication and Interpretation of X-rays or Records

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

Facility Fees
Including additional fees charged by the dentist for hospital, state approved community health and developmental disabilities program, extended care facility or home care treatment, except for emergency care of members under age 19

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

Hypnosis

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

Implants (removal or placement)
See section 4.3.5 for alternative benefits.

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

Instructions or Training
Including tobacco cessation counseling for members age 19 and over, plaque control and oral hygiene or dietary instruction

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

Maxillofacial Prosthetics
Except for surgical stents as stated in section 4.3.5 and fluoride gel carriers for members under age 19

Medications
Except oral anesthesia medications for members under age 19 used during an in-office procedure.

Missed Appointment Charges

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

Orthodontia
Except for treatment of cleft palate or cleft palate with cleft lip for members under age 19

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

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

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

Rebuilding or Maintaining Chewing Surfaces; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except occlusal or athletic mouthguards as provided for in section 4.3.6. Excluded services include increasing vertical dimension, equilibration and periodontal splinting.

Self Treatment
Services provided by members to themselves

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

Services on Tongue, Lip, or Cheek

Services Otherwise Available
Including those services or supplies:

a. compensable under workers' compensation or employer's liability laws
b. provided by any city, county, state or federal law, except for Medicaid coverage
c. provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan

Taxes

Teledentistry Fees
A sparate charge for teledentistry is not covered. Teledentistry is covered in the normal charge for the service.

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party (see section 9.3.2)

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

Treatment After Coverage Terminates
Except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

Treatment of Closed Fractures

SECTION 7. ELIGIBILITY

If this is a child only plan, coverage is only available to age 26. Dependent children, spouses, and domestic partners of the subscriber are not covered. Disregard any reference to spouses, domestic partners or children. Siblings of the subscriber are eligible. Coverage of new siblings may be effective on either the date of birth, adoption or placement for adoption or the first of the following month.

A person cannot be covered by more than one Delta Dental individual dental policy at any time.

7.1 SUBSCRIBER

To be a subscriber, a person must be a resident in the state of Oregon and reside in the service area for at least 6 months out of the calendar year. Resident means a person who lives in the state of Oregon and intends to live in the state permanently or indefinitely. Coverage will not be available to a person who resides in Oregon for the primary purpose of obtaining health coverage.

To be eligible, a person must not have been covered on an individual Delta Dental policy for the past 12 months. In addition, a person is eligible for coverage on an individual Delta Dental policy a maximum of 3 times per lifetime.

7.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Foster children are eligible only while legally a foster child.

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

a. The biological, adopted or foster child of a subscriber or a subscriber's eligible spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has a disability making the child physically or mentally incapable of self-support is eligible for coverage even though the child is over 26 years old. If the child is eligible for overage coverage under themedical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, the subscriber must submit the medical carrier's determination that the child is eligible for overage coverage

to Delta Dental at least 45 days before the child's 26th birthday to avoid a break in coverage.

Periodic review by Delta Dental will be required unless the disability is certified to be permanent.

To be eligible, a person must not have been covered on an individual Delta Dental policy for the past 12 months. In addition, a person is eligible for coverage on an individual Delta Dental policy a maximum of 3 times per lifetime.

7.3 NEW DEPENDENTS

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply from the date coverage is effective.

If a subscriber marries or registers a domestic partnership while enrolled in this policy, the spouse or domestic partner and their children may be added to this policy by submitting a complete and signed application.

A member's newborn child is eligible from birth. A subscriber's adopted child, foster child or child placed for adoption is eligible on the date of placement. To enroll a new child, an application must be submitted. When a premium increase is required, the application and payment must be submitted within 60 days. If payment is required but not received, the child will not be covered. The child may only be added subsequently at the next open enrollment. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

7.4 ELIGIBILITY AUDIT

Delta Dental reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to medical, dental, and certain financial records and birth certificates, adoption paperwork, marriage certificates, domestic partner registration, proof of residency and any other evidence necessary to document eligibility on the Plan.

SECTION 8. ENROLLMENT

A complete and signed application must be submitted for persons to be enrolled in the policy. Delta Dental must be notified whenever there is a change of address.

8.1 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents by submitting an application and supporting documentation (e.g., marriage or birth certificate, placement or adoption paperwork, etc.) within 60 days of their eligibility. The subscriber must notify Delta Dental if family members are added or dropped from coverage, even if it does not affect premiums.

8.2 OPEN ENROLLMENT PERIODS

Persons can apply for coverage during the open enrollment period. For 2022, open enrollment is from November 1, 2021 to January 15, 2022. These dates may be different in future years.

8.3 SPECIAL ENROLLMENT PERIODS

Persons can apply for coverage or enroll in another individual plan within 60 days from the following qualifying events:

a. Loss of creditable dental coverage due to loss of eligibility, but not as a result of voluntary termination of coverage (except for termination of a non-calendar year plan on the last day of the plan year), non-payment of premium or rescission
b. Loss of coverage due to military discharge
c. Obtaining new dependents through marriage, domestic partner registration, birth, adoption or placement for adoption or foster care
d. Child support order or other court order requiring coverage of a dependent
e. Becoming enrolled or disenrolled as a result of the error, misrepresentation or inaction of the Marketplace and its agents, or of the U.S. Department of Health and Human Services (HHS)
f. Having adequate evidence that there is a violation of a material provision made by the qualified dental plan (QDP) in which the person is enrolled
g. Decertification of the QDP in which the person is enrolled
h. Becoming newly ineligible for advanced payments of the premium tax credit
i. Moving permanently to a new location with access to new QDPs
j. Gaining new access to a qualified small employer HRA (QSEHRA)
k. Loss of coverage of a non-calendar year QSEHRA due to non-renewal at the end of the plan year
l. Employer contributions or government subsidies for COBRA continuation coverage end

m. Failure to receive timely notice of a qualifying event and the person was unaware that a qualifying event occurred

In the case of the loss of creditable dental coverage, permanent move to new area with different QDP options, or when a person covered on a group plan becomes newly eligible for advance payments of the premium tax credit due to being ineligible for qualifying coverage on the group plan, a person has 60 days before or after the event to enroll.

Persons who did not receive timely notice of a qualifying event and were unaware that a qualifying event occurred may choose a new QDP within 60 days of the date they knew or reasonably should have known of the occurrence of the qualifying event. They may choose the effective date that would have been available if they had received timely notice of the qualifying event or another effective date that is otherwise available to them.

If coverage ends and a member changes from one Delta Dental individual plan to another during special enrollment, any amount that has been applied to the annual benefit maximum will be transferred to the new plan.

8.4 PREMIUMS

The current premium amount is shown either on the declaration page that comes with this policy or any subsequent premium change notice.

8.4.1 Making Payments

Premium payments are due monthly for continued coverage. Payments can be made by check, money order or prepaid debit card with a billing statement, or by electronic fund transfer (EFT). If a subscriber no longer wishes to pay by EFT, Delta Dental must be notified in writing 15 days before the next deduction date. For other changes in billing option, Delta Dental must receive 30 days prior written notice from the subscriber. Electronic billing (eBill) is also available, allowing subscribers to pay the monthly premium on Member Dashboard using their bank account.

Premium payments by third parties are not accepted, except when required by law.

8.4.2 When Payments are Due

All premium payments are due on the first of the month. Delta Dental will allow a 30-day grace period after the premium due date. This policy continues for each month a subscriber makes a timely premium payment. If payment is not received within the grace period, this policy will end after a 10-day advance notice. Coverage will end on the last day of the coverage period for which premiums were paid. If this policy ends because premiums have not been paid, Delta Dental may require payment of any unpaid past-due premiums from the last 12 months before open enrollment or special enrollment coverage under a new Delta Dental policy becomes effective.

8.4.3 Changes in Amount of Premiums

Premiums can change without notice when there is a change in the family composition. The new premium amount will be effective the first day of the month following the event.

When a member moves into the next age bracket of the rate table, premiums will change on the renewal date. 30 days written notice will be provided before a change in the premiums affecting all policyholders takes effect. When the new premium is paid, the payment will confirm the subscriber's acceptance of the change.

8.5 WHEN COVERAGE BEGINS

The initial premium payment must be made before the policy becomes effective. If the initial payment is not made within the grace period, this policy never goes into effect.

Coverage for new applicants begins on the 1st day of the month following receipt of the application, unless another month is selected.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. For new spouses or domestic partners coverage begins on the 1st of the month following receipt of the application.

Coverage begins for persons who qualify due to the loss of creditable dental coverage and apply on or before the loss of coverage on the 1st of the month following the loss of coverage. When there is a court order or military discharge, coverage begins on the effective date of the order or the date of discharge. Coverage for those enrolling during open enrollment begins on the date the policy renews.

In all cases, the required premium must also be paid for coverage to become effective.

8.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

8.6.1 Termination by Subscriber

A subscriber may terminate coverage, or coverage for any enrolled dependent, by giving Delta Dental 30 days prior written notice. Coverage ends on the last day of the month through which premiums are paid.

8.6.2 If Delta Dental Refuses to Renew

Delta Dental can refuse to renew this policy at the end of any period for which premiums are paid by giving 30 days advance written notice.

8.6.3 Rescission

Delta Dental may rescind a member's coverage back to the effective date, or deny claims at any time for fraud or intentional material misrepresentation. This may include but is not limited to enrolling ineligible persons in the policy, falsifying or withholding documentation or information that is the basis for eligibility, and falsification or alteration of claims. Delta Dental reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. A member will be notified of a rescission 30 days before cancellation of coverage. If coverage

terminates under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract, or the contract of any affiliates.

8.6.4 Death

If the subscriber dies, coverage for all enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may convert to coverage in their own names by filing a written application with Delta Dental and paying the required premium within 60 days after eligibility under this policy ends.

8.6.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered.
b. Coverage ends for enrolled children on the last day of the month in which they turn age 26, or that a legal guardianship ends.

The subscriber must notify Delta Dental when a marriage, domestic partnership or guardianship ends.

A former dependent may continue coverage by submitting a complete and signed application under their own name and paying the required premium within 60 days after eligibility under this policy ends.

8.6.6 Moving Out of State

Coverage will end if the subscriber no longer resides in the state of Oregon.

8.6.7 Reapplying for Coverage

When coverage is lost, there is no reinstatement. If the subscriber chooses to terminate coverage, or coverage is terminated due to non-payment or late payment of premiums, members will not be eligible to reapply for an individual Delta Dental policy for 12 months. Reapplication for a Delta Dental plan will be accepted a maximum of 2 times per member per lifetime. If reapplication follows a termination due to late premiums, premium payments must be through electronic fund transfer (EFT) upon acceptance.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

9.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred.

9.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through Member Dashboard. Delta Dental may pay claims, deny them, or apply the allowable expense toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 9.1.1.

9.1.3 Claim Inquiries

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

9.1.4 Time Frames for Processing Claims

If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond Delta Dental's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim.

9.2 APPEALS

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

9.2.1 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Delta Dental informing a person of 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 one based on a determination of a person's eligibility to participate in the Plan, and one 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.

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

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

9.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit a written appeal. If an appeal is not submitted within this timeframe, the member will lose the right to any appeal.

9.2.3 The Review Process

The Plan has a 2-level review process (a first level appeal and a second level appeal).

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

The member may review the claim file and submit evidence as part of the appeal process and may appoint a representative to act on the member's behalf.

9.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal.

Delta Dental will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the initial determination. Investigation of an appeal will be completed and notice will be sent within 30 days of receipt of the appeal. When an investigation has been completed, Delta Dental will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

9.2.5 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations and will follow the same timelines as those for a first

level appeal. Delta Dental will notify the member in writing of the decision, including the basis for the decision.

9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.3.1 Coordination of Benefits (COB)

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

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

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

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent**. If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together**. If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
c. **Dependent Child/Parents Separated or Divorced or Not Living Together**. If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.

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

d. **Dependent Child Covered by Individual Other than Parent**. For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child.
e. **Dependent Child Covered by Parent and Spouse/Domestic Partner**. For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee**. The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired), or as that employee's dependent, determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage**. If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage**. The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above**. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

9.3.1.2 How COB Works

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

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

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

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

9.3.1.3 Effect on the Benefits of this Plan

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

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

9.3.1.4 Definitions

For purposes of section 9.3.1, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

Complying plan is a plan that follows these COB rules.

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

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

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

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

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

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

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

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

9.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by Delta Dental. The policy does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 9.3.2.5 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to the member Delta Dental will pay a member's expenses based on the understanding and agreement that Delta Dental is entitled to be reimbursed from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that Delta Dental has the rights described in section 9.3.2. Delta Dental may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Delta Dental's right of recovery or subrogation as discussed in this section. Delta Dental has discretion to interpret and construe these recovery and subrogation provisions.

9.3.2.1 Definitions:

For purposes of section 9.3.2, the following definitions apply:

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

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

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

9.3.2.2 Subrogation

Upon payment by the Plan, Delta Dental has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such rights and do nothing to prejudice them. Delta Dental is entitled to all subrogation rights and remedies under common and statutory law, as well as under the policy.

9.3.2.3 Right of Recovery

In addition to its subrogation rights, Delta Dental may, at its sole discretion and option, require a member, and the member's attorney, if any, to protect its recovery rights. The following rules apply to all recovery, except for those related to motor vehicle accidents (see section 9.3.2.5 for motor vehicle recovery rights):

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

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

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

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

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

9.3.2.4 Additional Provisions

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

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

   i. Signing and delivering any documents Delta Dental reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 9.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.
   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.
   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing its third party recovery rights.

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

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

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 9.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 9.3.2.

f. Section 9.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Delta Dental.

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

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

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

9.3.2.5 Motor Vehicle Accidents Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Delta Dental and motor vehicle insurance has not yet paid, then Delta Dental will advance benefits. Delta Dental retains the right to repayment of any benefits paid from the proceeds of any settlement, judgment or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

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

The member shall do whatever is proper to secure, and may not prejudice, the rights of Delta Dental under this section.

SECTION 10. MISCELLANEOUS PROVISIONS

10.1 DISCLOSURE OF BENEFIT REDUCTION

Delta Dental will provide notification of material reductions in covered services or benefits to the subscriber no later than 30 days before the adoption of the change.

10.2 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

10.3 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Delta Dental. Protected health information includes enrollment, claims, and medical and dental information. Delta Dental uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how Delta Dental uses members' information. A copy of the notice is available on the Delta Dental website by following the HIPAA link or by calling 855-425-4192 .

10.4 TRANSFER OF BENEFITS

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

10.5 RECOVERY OF BENEFITS PAID BY MISTAKE

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

10.6 CORRECTION OF PAYMENTS

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

10.7 CONTRACT PROVISIONS

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

10.8 WARRANTIES

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

10.9 LIMITATION OF LIABILITY

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

10.10 PROVIDER REIMBURSEMENT

Under state law, dentists contracting with Delta Dental to provide services to members agree to look only to Delta Dental for payment of the part of the expense that is covered by the Plan and may not bill the member in the event Delta Dental fails to pay the dentist for whatever reason. The dentist may bill the member for applicable cost sharing or non-covered expenses except as may be restricted in the provider contract.

10.11 INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and participating dentists are independent contractors. Delta Dental and participating dentists do not have a relationship of employer and employee nor of

principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a participating dentist's provision of dental care to Delta Dental members may be deemed or construed to exist between Delta Dental and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and Delta Dental does not control the detail, manner or methods by which a participating dentist provides care.

10.12 No Waiver

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

10.13 Governing Law

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

10.14 Where any Legal Action Must be Filed

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

10.15 Time Limit for Filing a Lawsuit

Any legal action arising out of, or related to, this policy and filed against Delta Dental by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

SECTION 11. DEFINITIONS

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

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

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

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

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

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

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

Calendar Year means a period beginning January 1st and ending December 31st.

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

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

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

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

Covered Service is a service that is specifically described as a benefit of this policy.

Creditable coverage is prior dental coverage that allows a member to skip waiting periods for Class II and Class III services. Prior plan must include at least the benefits comparable to those shown in Section 4.4. Embedded pediatric benefits in medical plans are not considered creditable coverage.

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

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

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor.

Dentally Necessary means services that:

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

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

Dentist means a licensed dentist, operating within the scope of their license as required under law within the state of practice.

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

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

Domestic Partner means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.

Effective Date means the 1st of the following month if an application is received on the 1st to the 15th of a month, or the 1st of the second month if an application is received from the 16th to the last day of a month. For new dependents, effective date means the date of birth for a newborn child, the date of the adoption decree for an adopted child and the date of placement for a child placed for adoption or foster care. For new spouses and domestic partners and persons who qualify due to loss of creditable dental coverage it means the 1st day of the month following the qualifying event.

Emergency Services means services for a dental condition manifesting itself with acute symptoms that are severe enough to require immediate treatment. They include services to treat acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked-out tooth.

Exclusion Period means a period of time during which specified treatments or services are excluded from coverage.

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

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

Maximum Plan Allowance (MPA) is the maximum amount that Delta Dental will reimburse providers. For a Delta Dental PPO dentist and for non-participating dentists or dental care providers, the maximum amount is based on the PPO fee allowable. For a dentist participating only in the Premier network, the maximum amount is the dentist's filed or contracted fee with Delta Dental. When using a non-participating dentist or dental care provider, any amount above the MPA is the member's responsibility.

Member means a subscriber or dependent of a subscriber who is enrolled for coverage under the terms of this policy.

Non-participating Dentist or Dental Provider means a licensed dental provider who has not contracted to be part of the Delta Dental PPO network or the Delta Dental Premier network.

Out-of-Network Dentist or Dental Provider means a licensed dental provider who has not contracted as an in-network Delta Dental PPO dentist.

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

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

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

The **Plan** is the individual dental insurance plan insured under the terms of this policy between the subscriber and Delta Dental.

Policy means the contract between the subscriber and Delta Dental that contains all the conditions of the coverage. The policy includes this handbook, the individual's application with Delta Dental, and any declaration pages, addendums, endorsements or amendments.

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

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

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

Prophylaxis is cleaning and polishing of all teeth.

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

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

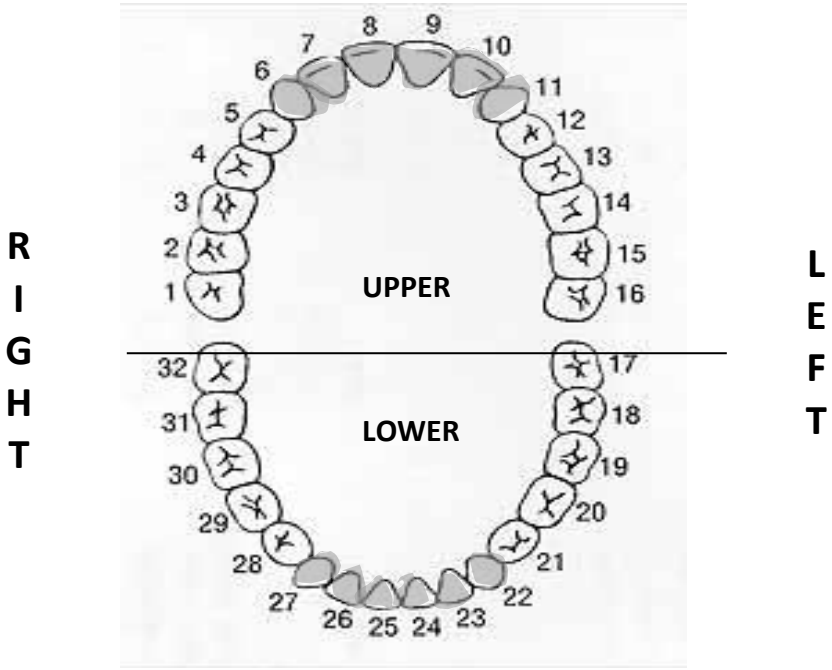
Retainer is a tooth used to support a prosthetic device (implant crowns, bridges, partial dentures or overdentures).

Subscriber means the person in whose name the policy is issued following acceptance by Delta Dental of that person's application.

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

SECTION 12. TOOTH CHART

THE PERMANENT ARCH



Anterior teeth are shaded gray.

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

Nondiscrimination notice

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

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

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

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

888-217-2365 (TDD/TTY 711)

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

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

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

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

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

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

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

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DeltaDentalAK.com | DeltaDentalOR.com

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 844-235-8013
(En Español: 877-299-9063)

P.O. Box 40384
Portland, OR 97204