Dental Only Plan

Part time Plan

Delta Dental Premier Plan

Effective Date: January 1, 2018

DeltaORASObk 1-1-2018

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

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SECTION 1. WELCOME

This handbook describes the main features of the Public Employees' Benefit Board (the Group) dental plan (the "Plan").

The Plan is self-funded by the Group and Oregon Dental Service (ODS), doing business as Delta Dental Plan of Oregon (abbreviated as Delta Dental) has been contracted to provide claims and other administrative services. Delta Dental is part of Moda, Inc.

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

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

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to **myModa**)
www.modahealth.com/pebb
(Use Find Care to find a participating dentist)

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

Telecommunications Relay Service for the hearing impaired
711

Public Employee's Benefit Board (PEBB)
503-373-1102

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

2.2 MEMBERSHIP CARD

After enrolling, members will receive identification cards that will include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to myModa or contact Customer Service for replacement of a lost identification card.

2.3 NETWORK

See Network Information (section 3.1) for more information about how to use the network.

Dental network
Delta Dental Premier Network

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 12 and Section 15.

SECTION 3. USING THE PLAN

For questions about the Plan, members should contact Customer Service.-For questions about eligibility and enrollment, members should contact the Public Employees' Benefit Board at 503-373-1102 or inquiries.pebb@state.or.us

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

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

3.1 NETWORK INFORMATION

Delta Dental's dental plans are easy to use and cost effective. If members choose a participating Delta Dental Premier dentist from the Delta Dental Premier Dental Directory (available on myModa by using "Find Care"), all of the paperwork takes place between Delta Dental and the dentist's office. 92% of all licensed dentists in Oregon are participating Delta Dental Premier dentists. For members 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 the Plan for participating Delta Dental Premier dentists and non-participating dentists or dental care providers. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

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 Plan's current benefits and returned to the dentist. The member and his or her dentist should review the information before beginning treatment.

SECTION 4. DEFINITIONS

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

Affidavit of Domestic Partnership is a signed document that attests the subscriber and one other eligible person meet the criteria in the affidavit to be unregistered domestic partners.

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 15)

Bicuspid is a premolar tooth, between the front and back teeth. (tooth chart in Section 15)

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, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network providers or the cost of non-covered services.

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

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

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

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

Dentally Necessary means services that:

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

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

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

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

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

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner as follows;

a. **Registered Domestic Partner** means a person of the same sex joined with the subscriber in a partnership that has been registered in Oregon according to the Oregon Family Fairness Act.
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Domestic Partner Affidavit on file with PEBB.

Eligible Employee for the purpose of this handbook, means an employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan.

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

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

Group Health Plan means any plan, fund or program established and maintained by the Group for the purpose of providing healthcare for its employees or their dependents through insurance, reimbursement or otherwise. This dental benefit plan is a group health plan.

Late Enrollee means a person who was previously eligible for coverage but was not enrolled.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with Delta Dental. For non-participating dentists or dental care providers, the maximum amount is based on a non-participating dentist fee schedule. When using a non-

participating dentist or dental care provider, any amount above the MPA is the member's responsibility.

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

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

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

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

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

The **Plan** is the dental benefit plan sponsored and funded by the Group.

Plan Sponsor means the Group.

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

Posterior refers to teeth located toward the back of the mouth. (tooth chart in Section 15)

Prophylaxis is cleaning and polishing of all teeth.

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

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

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

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

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

Waiting Period means the period that must pass before a late enrollee is eligible to receive benefits under the Plan for Basic and Major services.

SECTION 5. BENEFIT SUMMARY

Calendar year maximum	$1,250
Calendar year deductible per member	$ 50

Service	Benefit Amount
Diagnostic & Preventive - Deductible applies Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	**100%**
Basic - Deductible applies Restorative Dentistry Oral Surgery Endodontics Periodontics	**50%**
Major - Deductible applies Bridges Dentures Crowns Cast Restoration Implants Athletic Mouthguards Nightguards (occlusal guards) up to $150 maximum	**50%**

Note: Late enrollees (meaning persons who were previously eligible for coverage but were not enrolled) have a 12 month waiting period for Basic and Major services. Late enrollees who enroll in this Plan directly from a Delta Dental plan or another PEBB dental plan with 12 months of consecutive coverage without lapse are not subject to the waiting periods. (See section 9.2 for additional information).

5.1 NON-PARTICIPATING DENTISTS

A small percentage of the licensed, practicing dentists and dental providers in Oregon are not participating with Delta Dental. Each dentist or dental provider has a right to make such a decision. If a member receives treatment from a non-participating dentist or dental provider, the dentist or dental provider should complete a standard claim form, but may require that it be submitted directly to Delta Dental. The Plan requires that amounts payable for services of a non-participating dentist or dental provider be limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance. Non-participating dentists and dental providers may charge more than the Delta Dental allowable and the member is responsible for the entire amount which exceeds the maximum plan allowance.

5.2 PAYMENT BASED ON ACTUAL FEES

The benefit amounts for various services are listed above. The percentages are applied to the actual fees of the participating Delta Dental Premier dentists. THESE FEES HAVE PREVIOUSLY BEEN FILED WITH, AND APPROVED BY Delta Dental. THE DENTIST MAY NOT CHARGE THE MEMBER MORE THAN HIS OR HER FILED FEES.

SECTION 6. 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 (accidental injury coverage is secondary to medical). Delta Dental's dental consultants and dental director shall determine these standards.

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

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

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

Limitations may apply to these services, and are noted below. See Section 8 for exclusions.

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

Deductible: $50
Per member per year, or portion thereof.
Deductible applies to all covered dental services.

Maximum payment limit: $1,250
Per member per year, or portion thereof.
Covered Diagnostic and Preventive services do not apply to maximum payment limit.

6.1 DIAGNOSTIC AND PREVENTIVE SERVICES
COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE.

6.1.1 Diagnostic

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

b. Diagnostic Limitations:
- i. Periodic (routine) or comprehensive examinations or consultations are covered twice per year.
- ii. Complete series x-rays or a panoramic film is covered once in any 5-year period. This time period is calculated from the previous date of service.

iii. Supplementary bitewing x-rays are covered once per year for children under 15 years of age and once in a 2-year period for members age 15 years of age and older.
iv. A member may qualify for a higher x-ray frequency based on the dentist's assessment of the member's oral health and risk factors. (The maximum frequency, available only by dentist assessment, is bitewings twice per year; complete series or panoramic once in a 3-year 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 by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.

6.1.2 Preventive

a. Preventive Services:

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

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year unless the dentist's assessment of the member's oral health and risk factors indicates the need for more frequent cleanings. (The maximum frequency, available only by dentist assessment, is four cleanings per year.) Refer to section 6.2.4, Periodontal benefits, for frequency and limitations on periodontal maintenance.
ii. Topical application of fluoride is covered twice per year for members age 18 and under. For members age 19 and over, topical application of fluoride is covered twice per year 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).
iii. 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.
iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 and over are not covered.

6.2 BASIC SERVICES
COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE.

6.2.1 Restorative

a. Restorative Services:

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

b. Restorative Limitations:

i. Composite, resin, or similar (tooth colored) restorations in posterior teeth are considered optional services. If a composite or similar filling is used to restore posterior teeth, benefits are limited to the amount paid for an amalgam filling. The member is responsible for paying the difference.

ii. Inlays are considered an optional service; an alternate benefit of an amalgam 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. Additional limitations when teeth are restored with crowns or cast restorations are in section 6.3.1.

v. Replacement of a stainless steel crown by the same dentist within 24 months of placement is not covered. The replacement is included in the charge for the original crown.

6.2.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical)

ii. Other minor surgical procedures

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.

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

6.2.3 Endodontic

a. Endodontic Services:

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

b. Endodontic Limitations:

i. A separate charge for cultures is not covered

ii. Pulp capping is covered only when there is exposure of the pulp.

iii. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

6.2.4 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 not covered unless the dentist's assessment of the member's oral health and risk factors indicates the need. (The highest frequency, available only by dentist assessment, is four prophylaxis and/or periodontal maintenance, per year.)

iii. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
iv. Full mouth debridement is limited to once in a 2-year period and, if the member is age 19 or older, only if there has been no cleaning (prophylaxis, periodontal maintenance) within a 2-year period.

6.2.5 Anesthesia

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

6.3 MAJOR SERVICES.
COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

6.3.1 Restorative

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

b. Restorative Limitations:
i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 6.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

6.3.2 Prosthodontic

a. Prosthodontic Services:
i. Bridges
ii. Partial and complete dentures
iii. Denture relines
iv. Repair of an existing prosthetic device

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 and repairs 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.

v. Tissue conditioning is covered no more than twice per denture in a 36-month period.

vi. 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 in any 7-year period; or
   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.

vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.

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

6.3.3 Other

a. Other Services:

i. Athletic mouthguard
ii. Nightguard (Occlusal guard)

b. Other Limitations:

i. An athletic mouthguard is covered once in any 12 month period for members age 15 and under and once in any 24 month period for age 16 and over. The time period is calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.

ii. A nightguard (occlusal guard) is covered once every 5 years at 50% up to $150 maximum. Over-the-counter nightguards are excluded.

6.4 GENERAL LIMITATION – OPTIONAL SERVICES

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

SECTION 7. HEALTH THROUGH ORAL WELLNESS

Delta Dental's Health through Oral Wellness program offers enhanced benefits to members who are at greater risk of oral disease or medical complications related to oral health. Qualification for the program requires members take a clinical risk assessment from a registered dentist.

A registered dentist is a licensed dentist who has registered with the Health through Oral Wellness program and agreed to perform a clinical risk assessment as part of a member visit. To find a registered dentist, members should contact Customer Service at 888-217-2365.

7.1 ENHANCED BENEFITS

Members who qualify for enhanced benefits under the Health through Oral Wellness program receive additional benefits that may include:

i. Prophylaxis (cleanings),
ii. Fluoride treatments,
iii. Sealants,
iv. Periodontal maintenance,
v. Drugs or medicaments dispensed in the office for home use,
vi. Oral hygiene instruction,
vii. Nutritional counseling, or
viii. Tobacco cessation counseling.

Enhanced benefits are subject to the Plan's maximum payment limit, deductible, coinsurance and other limitations.

Enhanced benefits may not be combined with any additional prophylaxis and periodontal maintenance services based on a dentist's assessment of the member's oral health and risk factors as described in sections 6.1.2 and 6.2.4.

7.2 QUALIFYING FOR ENHANCED BENEFITS

To qualify for enhanced benefits, members are required to receive a clinical risk assessment from a registered dentist. The clinical risk assessment objectively determines a member's risk of tooth decay, gum disease and oral cancer, assigning a risk score upon completion. A member with a qualifying risk score is informed of his or her enhanced benefits by the registered dentist. Subsequent assessments may be required to maintain a member's qualification for enhanced benefits.

For more information about the Health through Oral Wellness program, members should visit www.modahealth.com/pebb or contact Customer Service at 888-217-2365.

7.3 When Enhanced Benefits End

When a member's oral health improves and their clinical risk assessment yields a lower score, enhanced benefits may end on the first of the following month.

SECTION 8. EXCLUSIONS

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

Analgesics

Anesthesia or Sedation
Local anesthetics, Nitrous oxide, General anesthesia and/or IV sedation except as stated in section 6.2.5

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

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service, except as stated in section 10.1.

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

Cosmetic Services

Duplication and Interpretation of X-rays

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

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

Gnathologic Recordings

Hypnosis

Illegal Acts, Riot or Rebellion, War
Services and supplies for treatment of an injury or condition caused by or arising out of a member's voluntary participation in a riot or arising directly from an illegal act. This includes any expense caused by, arising out of or related to 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 6.3.2 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, Counseling or Training
Including plaque control, oral hygiene or dietary instruction, and tobacco cessation counseling, except as provided through the Health through Oral Wellness program (see Section 7)

Localized Delivery of Antimicrobial Agents

Medications

Missed Appointment Charges

Never Events
Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth

Orthodontia

Over the Counter
Over the counter occlusal guards and athletic mouthguards

Periodontal Charting

Precision Attachments

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

Self-Treatment
Services provided by a member to herself or himself

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
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Taxes
A separate charge for taxes.

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. (See section 10.3.2)

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

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

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

SECTION 9. ELIGIBILITY

The Public Employees' Benefit Board (PEBB) eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees should refer to the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

SPECIAL RULES REGARDING ENROLLMENT IN THE DENTAL PLAN

9.1 Employees and eligible family members have the option to enroll in the dental plan. The employee and/or family members enrolled in the dental plan do not have to match the employee and/or family members enrolled in the medical plan. Employees may enroll family members within 30 days of a qualified midyear change event. The qualifying change event and the requested enrollment must be consistent under IRS rules. **Family members added due to a midyear change event are not subject to the waiting period limitations. (See 9.2, below).**

9.2 NOTE: The waiting period applies to coverage for an eligible employee and family members if:

a. The employee waits until an open enrollment period to enroll himself or herself or any eligible family members
b. The employee removes family members from the dental plan for a period of 12 months or more and then re-enrolls them during open enrollment

9.3 Employees who change from one dental plan to another during the open enrollment period or due to a move out of service area are not subject to the waiting period.

9.4 Late enrollees who enroll in this Plan directly from a Delta Dental plan or another PEBB dental plan with 12 months of consecutive coverage without lapse are not subject to the waiting period. Please contact Delta Dental at 888-217-2365 if this applies.

9.5 Employees whose family members involuntarily lose coverage on another group dental plan may add their family members to their dental plan within 30 days of loss of dental coverage. Individuals enrolled under this provision are not subject to the waiting period.

SECTION 10. CLAIMS ADMINISTRATION AND PAYMENT

10.1 SUBMISSION AND PAYMENT OF CLAIMS

10.1.1 Claim Submission

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

10.1.2 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.1.

10.1.3 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. The Plan will respond to an inquiry within 30 days of receipt.

10.2 APPEALS

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Delta Dental, in the form of a letter or an Explanation of Benefits (EOB), or 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 his or her 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.

10.2.2 Time Limit for Submitting Appeals

Members have **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeal process will be lost.

10.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level and a second level appeal. Delta Dental's response time to an appeal is based on the nature of the claim as described below.

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

10.2.4 First Level Appeal

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Delta Dental will conduct an investigation by persons who were not previously involved in the original determination.

When an investigation has been completed, Delta Dental will send a written notice of the decision to the member, including the basis for the decision. The investigation will be completed and notice sent within 30 days of receipt of the appeal. If applicable, the notice will include information on the right to a second level appeal.

10.2.5 Second Level Appeal

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal. Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal by persons who were not involved in the initial determinations, and will follow the same timeline as those for a first level appeal. Delta Dental will notify the member in writing of the decision, including the basis for the decision.

10.3 Benefits Available From Other Sources

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

10.3.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 11.

10.3.2 Third-Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover

benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member, the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed in full from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in section 10.3.2. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. The Plan has discretion to interpret and construe these recovery and subrogation provisions.

10.3.2.1 Definitions:
For purposes of section 10.3.2, the following definitions apply:

Benefits means any amount paid by the Plan, or submitted to Delta Dental 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.

Recovery Funds means any amount recovered from a third party.

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

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

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

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

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

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

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

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

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

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

10.3.2.4 Additional Provisions

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

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

   i. Signing and delivering any documents the Plan reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to the Plan relevant to the application of the provisions of section 10.3.2, 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 the Plan 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 the Plan by the member's provider
   iv. Taking such actions as the Plan 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 the Plan in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party

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

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 10.3.2

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 10.3.2

f. Section 10.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

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

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

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

SECTION 11. COORDINATION OF BENEFITS

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

11.1 DEFINITIONS

For purposes of Section 11, 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 complies with these COB rules.

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

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

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

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

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

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

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

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

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

11.2 How COB Works

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

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

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

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

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

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

The first of the following rules that applies will govern:

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

11.4 EFFECT ON THE BENEFITS OF THIS PLAN

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

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

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 DELTA DENTAL'S 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.

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

12.3 TRANSFER OF BENEFITS

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

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CORRECTION OF PAYMENTS

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

12.6 CONTRACT PROVISIONS

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

12.7 WARRANTIES

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

12.8 LIMITATION OF LIABILITY

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

12.9 PROVIDER REIMBURSEMENTS

Providers contracting with Delta Dental to provide services to members agree to look only to the Plan for payment of the part of the expense that is covered by the Plan and may not bill the member in the event the Plan fails to pay the provider 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.

12.10 INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and participating dentists are independent contractors. Delta Dental and participating dentists do not have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a participating dentist's provision of dental care to 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.

12.11 No Waiver

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

12.12 Group is the Agent

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

12.13 Governing Law

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

12.14 Where any Legal Action Must be Filed

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

12.15 Time Limits for Filing a Lawsuit

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

12.16 Rescission

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

SECTION 13. CONTINUATION OF DENTAL COVERAGE

Continuation of coverage under the PEBB program is governed under Chapter 101, Division 30 of the Oregon Administrative Rules. The following is a summary of continuation coverage for spouses aged 55 years or older, and continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). There may be additional continuation options available; employees should refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

13.1 OREGON CONTINUATION COVERAGE FOR SPOUSES AND DOMESTIC PARTNERS AGE 55 AND OVER

13.1.1 Introduction

55+ Oregon Continuation only applies to employers with 20 or more employees. The Plan will provide 55+ Oregon Continuation coverage to those members who elect coverage, subject to the following conditions:

a. The Plan will offer no greater rights than ORS 743B.343 to 743B.345 requires
b. The Plan will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice requirements outlined below
c. The Group or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group or its designated third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Plan shall be responsible for such premiums.

Note: In section 13.1 the term “domestic partner” refers to a registered domestic partner or an unregistered domestic partner, as defined in Section 4.

13.1.2 Eligibility

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or domestic partner is 55 years of age or older at the time of such event
c. The spouse or domestic partner is not eligible for Medicare

13.1.3 Notice And Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a legally separated or divorced or spouse domestic partner who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator fails to provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

13.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse or domestic partner, to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

13.1.5 When Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following events:

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan terminates coverage unless a different group plan is made available to the members
c. The date the member becomes covered under any other group dental plan
d. The date the member remarries or registers another domestic partnership
e. The date the member becomes eligible for Medicare

13.2 COBRA CONTINUATION COVERAGE

COBRA continuation is administered by a COBRA Administrator. The Plan Sponsor, the Public Employees' Benefit Board (PEBB) is located at 1225 Ferry Street SE in Salem, Oregon or at (503) 373-1102 or 1-800-788-0520 for more information.

13.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. Other than the exception on domestic partner coverage, the Plan will offer no greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the notice, election, or other requirements outlined below

13.2.2 Qualifying Events

a. **Subscriber.** A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment) or a reduction in hours.

b. **Spouse.** The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

   i. Death of the subscriber
   ii. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
   iii. Divorce or legal separation from the subscriber
   iv. The subscriber becomes entitled to Medicare

   (Also, if a subscriber eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

c. **Children.** A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

   i. Death of the subscriber
   ii. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
   iii. Parents' divorce or legal separation, or termination of a domestic partnership
   iv. Subscriber becomes entitled to Medicare
   v. Child ceases to be a "child" under the Plan

d. **Domestic Partners.** A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

13.2.3 Other Coverage

The right to elect continuation coverage shall be available to persons who are entitled to Medicare at the time of the election or are covered under another group dental plan at the time of the election.

13.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the

affected member; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct) or reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

13.2.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. The Plan will not send a bill for any payments due. The member is responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

13.2.6 Length of Continuation Coverage

18-Month Continuation Period. In the case of a loss of coverage due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, termination of a domestic partnership, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months

before the qualifying event, COBRA coverage under the Plan for members (other than the subscriber) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months ***before*** the termination or reduction of hours.

13.2.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member fails to provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the COBRA Administrator is notified in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination
b. the date of the subscriber's termination of employment or reduction of hours
c. the date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours

A member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 13.1).

13.2.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (e.g., age). The subscriber or a family member must notify the COBRA Administrator within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the COBRA Administrator in a timely fashion, the child will not be eligible for continuation coverage.

13.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

13.2.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time
b. a member becomes covered under another group dental plan (this does not apply to CHAMPUS or Tri-Care)
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA
d. the Group ceases to provide any group dental plan for its employees
e. during a disability extension period (see section 13.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

13.2.11 Address Changes

PEBB needs to be informed of any changes in the addresses of family members. Members should also keep a copy in their records, of any notices sent to PEBB.

13.2.12 Questions

This notice is simply a summary of potential future options under COBRA. Should an actual qualifying event occur and it is determined that a member is eligible for COBRA, he or she will be notified of the COBRA rights at that time. If any member does not understand any part of this

summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at:

503-373-1102
inquiries.pebb@state.or.us
http://pebb.das.state.or.us

The nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

SECTION 14. PROTECTED HEALTH INFORMATION

Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Delta Dental may disclose de-identified summary health information to PEBB for purposes of modifying, amending or terminating this Plan. In addition, Delta Dental may disclose protected health information (PHI) to PEBB in accordance with the following provisions of this Plan as established by PEBB:

a. PEBB may use and disclose the PHI it receives only for the following purposes:
    i. Administration of the Plan; and
    ii. Any use or disclosure as required by law.
b. PEBB shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to PEBB with respect to such information.
c. PEBB shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of PEBB.
d. PEBB shall report to Delta Dental any use or disclosure of PHI that is inconsistent with the provisions of this section of which the PEBB becomes aware.
e. PEBB shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.
f. PEBB shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.
g. PEBB shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.
h. PEBB shall make its internal practices, books and records relating to the use and disclosure of PHI received from Delta Dental available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
i. PEBB shall, if feasible, return or destroy all PHI received from Delta Dental and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. PEBB shall provide for adequate separation between PEBB and Delta Dental with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of PEBB or designated individuals:
    i. Benefit Manager;
    ii. Director of Operations;
    iii. PEBB's Designated Consultants; and
    iv. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

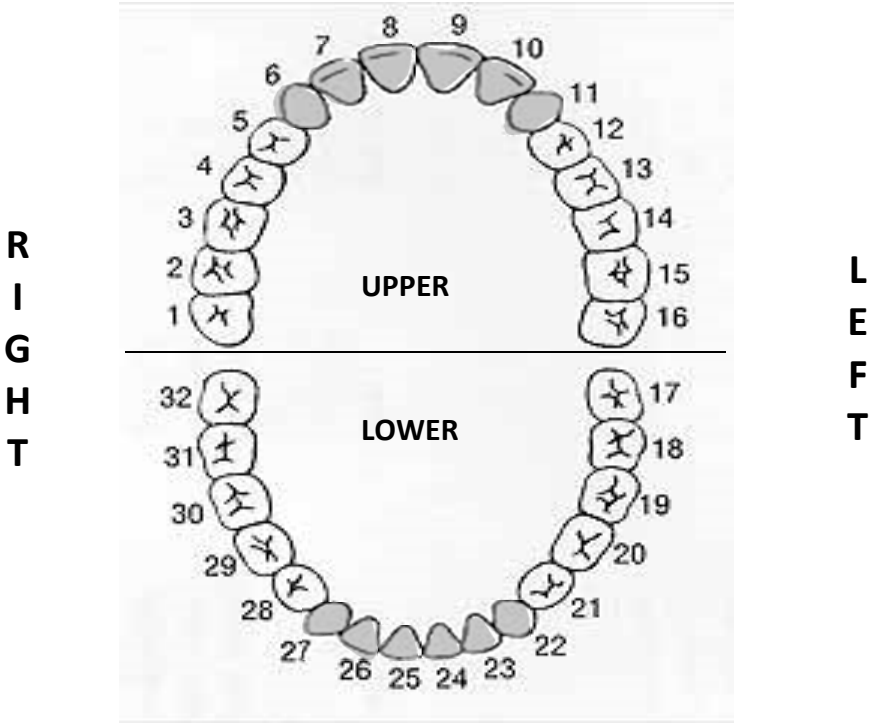
Further, PEBB shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for PEBB with regard to this Plan. In addition, PEBB shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

Security: In accordance with the security standards of HIPAA, PEBB shall:

a. Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
b. Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;
c. Ensure that any agent or subcontractor to whom PEBB provides PHI agrees to implement appropriate security measures to protect such information; and
d. Report to the Plan any successful security incident regarding PHI of which PEBB becomes aware.

SECTION 15. TOOTH CHART

THE PERMANENT ARCH



Note: 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)

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:

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

800-868-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. 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. 15019019 (8/16)

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).

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）

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

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

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

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 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)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 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。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 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.

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)

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

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ 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.

DELTA DENTAL

Delta Dental of Oregon & Alaska

moda HEALTH

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

P.O. Box 40384
Portland, OR 97240

Member Inquiries
Toll-Free 888-217-2365
Relay Service 711 (for the hearing and speech impaired)
Llamado Gratis 877-299-9063

www.modahealth.com