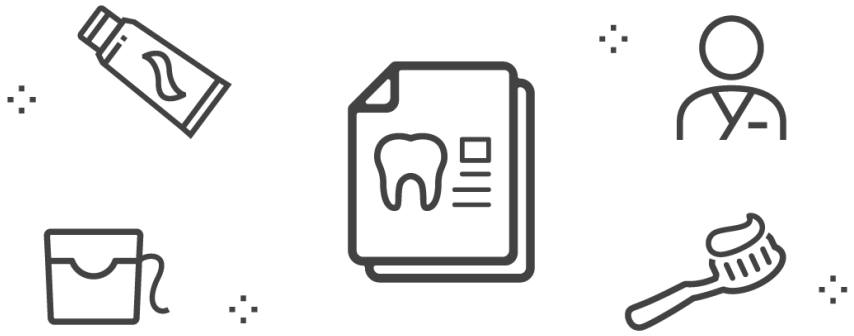
DELTA DENTAL®



2026

Oregon Group Dental Plan

Group Name
Voluntary Stand Alone Direct Option 1
Effective Date: January 1, 2026
Group Number: 123456789

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SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON

We are pleased your Group has chosen Delta Dental Plan of Oregon (abbreviated as Delta Dental) as its dental plan. This handbook will give you important information about the Plan's benefits, limitations and procedures.

Dental care services on this Delta Dental plan are provided by Willamette Dental. If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.DeltaDentalOR.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it's convenient.

This handbook may be changed or replaced at any time, by the Group or Delta Dental, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's policy with Delta Dental. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Delta Dental determines there is a legitimate business purpose for doing so.

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to your **Member Dashboard**)
www.DeltaDentalOR.com

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

Willamette Dental Group Member Services Department
Toll-free 855-433-6825, Option 3

Willamette Dental Group Website
www.willamettedental.com

Selecting and Making Appointments with a Willamette Dental Dentist
Toll-free 855-433-6825, Option 1

Eligibility Questions
Toll-free 888-217-2365
En español 877-299-9063

Filing Claims
Willamette Dental Group
Attention: Out of Area ER
6950 NE Campus Way
Hillsboro, OR 97124
Email: claimsquest@willamettedental.com

Appeals
Toll-free 855-433-6825, Option 2
Willamette Dental Group
Attention: Member Services Department
6950 NE Campus Way
Hillsboro, OR 97124

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers. Show your card each time you receive services, so your dentist will know you are a Delta Dental member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

2.3 NETWORK

The Plan pays benefits only for services provided in the network shown below.

Dental network
Willamette Dental

2.4 OTHER RESOURCES

You can find other general information about the Plan in Section 12.

SECTION 3. USING THE PLAN

This Delta Dental plan is easy to use. All of the paperwork takes place at the dentist's office. You do not submit claims for reimbursement, unless you get treatment for an out of area dental emergency. We pay for services you get from dentists in the Willamette Dental network.

All services must be provided by a Willamette Dental dentist in order to be covered, except when your Willamette Dental dentist refers you to an outside dentist or specialist, or if you have a dental emergency and you are out of the area.

You may choose any general dentist from the Willamette Dental Directory, which is on the Willamette Dental website. Call the "Selecting a Dentist" phone number in section 2.1 if you need help.

When you need dental care, make an appointment with a network dentist in advance. You must pay your member copayments at the time you get the dental service. The amount you pay for a covered service is listed in Section 13. If necessary, your Willamette Dental dentist will refer you to an outside dentist or specialist. **Dental services you get from an outside dentist or specialist are not covered** unless you have a referral from a network dentist or for an out of area dental emergency.

If you have questions about the Plan, contact Customer Service. This handbook describes the benefits of the Plan. Review this handbook carefully. It is your responsibility to be aware of the Plan's limitations and exclusions.

SECTION 4. BENEFITS & LIMITATIONS

The Plan covers services you get from a Willamette Dental provider. Some procedures require a copayment (see Section 13). You must pay this amount directly to your in-network dentist. Dental services you get from an outside dentist or dental care provider generally are not covered. You will have to pay all of the charges. (See section 4.3 exceptions.)

Before visiting a dental provider, call Willamette Dental and make an appointment. If you need to change a scheduled appointment, call in advance to cancel and re-schedule for another day. You will have to pay a missed appointment fee if your appointment is cancelled with less than 24 hours' notice.

4.1 MEMBER COPAYMENT SCHEDULE

A detailed list of covered services and copayments is in Section 13.

There is an annual out-of-pocket maximum for members under age 19. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid your maximum amount, we will pay 100% of your covered services for the rest of the year. You will always have to pay disallowed charges, even after your out-of-pocket maximum is met. This includes cost sharing for:

a. Services you get from an outside dentist
b. Orthodontic treatment other than to treat cleft palate, with or without cleft lip
c. Covered under any other insurance policy

4.2 BENEFITS AND LIMITATIONS

4.2.1 Teeth Cleaning

Your dentist decides how often you get your teeth cleaned based on what is dentally necessary for you. How often you get other diagnostic and preventive services is also decided by your dentist.

4.2.2 Anesthesia and Medications

The following services are only covered for members under age 19:

a. General anesthesia and IV sedation. You must have concurrent needs based upon age, physical, medical or mental state, or difficulty of the procedure.
b. Oral medication used during a procedure. "Take home" medication is not covered.

Non-intravenous conscious sedation is only covered for members under age 13, to a maximum of 4 times per year. Monitoring and nitrous oxide are included.

4.2.3 Endodontic Retreatment

When root canal therapy is done by a Willamette Dental dentist, retreatment is covered as part of the initial treatment for the first 24 months. After that time, you will have to pay the standard cost sharing.

4.2.4 Hospital and Other Facility Care

Hospital facility charges are not covered. The services you get in a hospital may be covered. They are only covered when:

a. A hospital setting is dentally necessary, and
b. Willamette Dental authorizes the services in writing, in advance

Services provided in a house or extended care facility are covered only for urgent or emergency visits for members under age 19.

4.3 REFERRED DENTAL CARE

If your Willamette Dental dentist refers you to an outside specialist for services that are covered under the Plan, you only have to pay your copayments (see Section 13) and any applicable service charges.

The Plan does not cover treatment that is not authorized by a Willamette Dental dentist. You must pay any charges by the outside dentist or specialist for any procedures that are not specifically referred/authorized by your network dentist.

4.4 EMERGENCIES

If there is an emergency, call your Willamette Dental provider to schedule an emergency appointment. You must pay the office visit copayment shown in Section 13 if you get your emergency services during office hours. For after-hours emergencies, you must also pay a separate after-hours copayment.

Most Willamette Dental offices are open 7:00 a.m. to 5:30 p.m., Monday through Friday and some Saturdays 7:00 a.m. to 1:00 p.m.

4.4.1 Out of Area Emergencies

If you have a dental emergency while you are traveling at least 50 miles from a Willamette Dental office and you are not able to get to a Willamette Dental provider, you may go to any licensed dentist for emergency treatment. You will have to pay for out of area emergency treatment by an outside dentist and then send a claim to Willamette Dental for reimbursement (see section 8.1). The maximum amount the Plan will pay is $100 per visit (after you have paid your applicable copayments). For after-hours emergencies, you also must pay a separate after-hours emergency care copayment.

4.5 BENEFITS AFTER COVERAGE ENDS

Dental benefits will be extended to cover the following services and supplies if your coverage ends for any reason **except**:

a. Not paying your premium
b. Willamette Dental ends its relationship with you (see section 9.5.5)

4.5.1 Crowns and Bridges

When the final impressions are taken before your coverage ends:

a. Seating the crown or bridge is covered up to 60 days after the end of coverage.
b. Adjustments are covered up to 6 months after seating.

4.5.2 Removable Prosthetic Devices

When final impressions are taken before your coverage ends:

a. Delivery of the prosthesis is covered up to 60 days after the end of coverage.
b. Adjustments are covered up to 6 months after seating.
c. Laboratory relines are not covered after your coverage ends.

4.5.3 Immediate Dentures

When final impressions are taken before your coverage ends:

a. Delivery of the dentures is covered up to 60 days after the end of coverage.
b. If coverage ends before your teeth are extracted, the extractions are not covered.

4.5.4 Root Canal Therapy and Root Canal Retreatment

When the root canal is started before your coverage ends:

a. Completion of treatment is covered up to 60 days after the end of coverage.
b. A pulpotomy is definitive treatment. It is not a root canal start.
c. If the root canal fails more than 60 days after the date of treatment and your coverage has ended, retreatment is not covered.
d. Restorative work is a separate procedure and is not covered after your coverage ends.

4.5.5 Extractions

When extractions are done before your coverage ends:

a. Post-operative visits are covered for 60 days after the date of the extraction.
b. Extractions are separate from prosthetic procedures. If you have teeth extracted in preparation for a prosthetic device, but your coverage ends before the final impressions, the prosthetic device is not covered.

SECTION 5. ORTHODONTIC BENEFIT

Orthodontic services are the procedures for correcting malocclusioned teeth. Treatment includes full consultation, x-rays, study models, case presentation and required appliances.

There is no deductible or lifetime maximum benefit amount. The Plan pays 100% after your cost sharing (see Section 13). The pre-orthodontic service copayment is credited toward the overall orthodontic copayment.

Limitations
Orthodontic treatment that began before you became covered under the Plan will be pro-rated (your copayments may be adjusted) based upon the services necessary to complete treatment.

If your coverage ends before your orthodontic treatment is complete, you may have to pay for orthodontic services you get after your coverage ends.

You will have to pay the General Office Visit copayment listed in Section 13 at each visit for orthodontic treatment. Other services you get in connection with orthodontic treatment (such as extractions or frenectomy) are separate from the orthodontic treatment. You must pay the copayments listed in Section 13 for those services in addition to the copayment for comprehensive orthodontia treatment.

SECTION 6. DENTAL IMPLANT SURGERY

6.1 DENTAL IMPLANT SURGERY BENEFITS

Dental implant surgery is covered as described in this section.

a. A Willamette Dental dentist:
    i. Agrees that dental implants are dentally appropriate for you.
    ii. Prepares a treatment plan for dental implants before starting any implant treatment.

b. You must:
    i. Get all dental implant services from a Willamette Dental dentist (unless you are given a referral to an outside dentist).
    ii. Follow the treatment plan.
    iii. Pay the amounts due.

These dental implant services are covered. You will pay 0%:
a. Surgical placement of implant body: endosteal implant (D6010)
b. Second stage implant surgery (D6011)

6.2 LIMITATIONS

The benefit for dental implants has these limitations:
a. The most the Plan pays for dental implant services in a calendar year is $1,500.
b. The Plan covers surgical placement of 1 dental implant per calendar year.
c. Dental implants to replace an existing bridge or denture are not covered, unless it has been at least 5 years since you got the bridge or denture.
d. If your coverage ends before your dental implant services are complete, you pay the cost of any remaining treatment.

6.3 EXCLUSIONS

These services are not covered under the dental implant benefit:
a. Any implant or related services that are not listed as covered above and/or in Section 13.
b. Bone grafting.
c. Cone beam CT x-rays and tomographic surveys.
d. Implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges and dentures).
e. A dental implant that is surgically placed before you are covered on the Plan and that has not received the final restoration.
f. Maintenance, repair, replacement or completion of an existing implant started or placed
    i. by an outside dentist without a referral from a Willamette Dental dentist.
    ii. before your coverage is effective.
g. Eposteal, transosteal, endodontic endosseous or mini dental implants.
h. Treatment of primary or transitional dentition.

SECTION 7. EXCLUSIONS

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

Accidental Injury
Treatment of accidental injury to natural teeth more than 12 months after the date of the accident

Anesthesia or Sedation
Except as described in section 4.2.2

Benefits Not Stated
Services or supplies not included in this handbook as covered services, unless required by law to meet pediatric dental coverage requirements

Cast Dowel Posts

Claims Not Submitted Timely
Claims for out-of-area emergencies submitted more than 6 months after the date of service

Congenital or Developmental Malformations
Includes treating cleft palate, jaw malformations, enamel hypoplasia, ectodental dysplasia and fluorosis (discoloration of teeth). Orthodontia to treat cleft palate may be covered if you are under age 19 (see Section 5).

Cosmetic Services
Any service or supply with the main purpose of changing or maintaining your appearance that will not result in significant improvement in dental function. An example is bleaching

Experimental or Investigational Procedures
Including expenses related to or needed because of such procedures

Facility Fees
Including additional fees charged by the dentist for hospital, extended care facility or home care treatment (except as described in section 4.2.4)

Federal, State or Governmental Program
When one of these programs covers your services, except where the Plan is required by law to cover them (such as in an emergency or for Medicaid coverage)

Full-Mouth Reconstruction

Habit-Breaking or Stress-Breaking Appliances

Illegal Acts
Services and supplies to treat an injury or condition caused by or arising directly from your illegal act.

Inmates
Services and supplies you get while you are in the custody of any state or federal law enforcement authorities or while in jail or prison

Intentionally Self-Inflicted Injuries
Being under the influence of any chemical substance is not considered a limitation on your ability to form the intent specified in this exclusion.

Materials Not Approved by the American Dental Association

Medications and Supplies
Except as described in section 4.2.2

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

Occupational Injury or Disease
Including any related to your self-employment

OSHA Requirements
Charges to comply with Occupational Safety and Health Administration (OSHA) requirements

Orthognathic Surgery

Precision Attachments and Other Special Techniques

Professional Athletic Activities
Treatment for injuries you get while you are practicing for or competing in a professional or semiprofessional athletic contest or event. These are events or activities you are paid or sponsored to do full-time or part-time.

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including splints, occlusal guards, nightguards and other appliances used to increase vertical dimension and restore bite

Repair and Replacement
Replacement of lost, missing or stolen dental appliances or dental appliances that are damaged due to abuse, misuse or neglect. Except, replacement of an existing denture, crown, inlay, onlay or other prosthetic appliance is covered if it is more than five years old and replacement is dentally necessary. If you are under age 19 and have acute trauma or catastrophic illness affecting your oral condition and resulting in additional tooth loss, an exception may also be made.

Restorations on Posterior Teeth
Veneers on posterior teeth

Self-Treatment
Services you provide to yourself

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

Services by an Outside Dentist
Unless a Willamette Dental dentist has referred you to an outside dentist, or when you have an emergency and are outside the Willamette Dental service area.

Services Not Provided by a Dental Provider
Charges by anyone other than a licensed dentist, licensed denturist or licensed hygienist

Services Otherwise Available
Someone else should have been responsible for the cost of these services or supplies, or you would not have had to pay if you were not covered by the Plan.

Taxes

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

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

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services and supplies that are:

a. Not dentally necessary to treat or prevent a dental injury or disease otherwise covered under the Plan
b. Inappropriate with regard to standards of good dental practice
c. Have a poor prognosis

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

Treatment with Multiple Visits

a. Treatment was started or ordered before your coverage began
b. Restoration or device was installed or delivered more than 60 days after your coverage ended

Tumor Related Services
Unless listed as covered in Section 13

SECTION 8. CLAIMS ADMINISTRATION & PAYMENT

8.1 SUBMISSION AND PAYMENT OF CLAIMS

When you see a Willamette Dental dentist, all of the paperwork takes place at the dentist's office. You do not need to submit claims.

If you get out of area emergency treatment by an outside dentist, you must pay the charges in full and then send a claim to Willamette Dental (address in section 2.1).

What to know about sending a claim from an outside dentist:

a. The claim form must be completely filled out. You and the dentist must sign it.
b. Include an itemized statement from the outside dentist. Willamette Dental may ask for more information if it is needed to process your claim. They must receive this information before your claim can be processed.
c. Willamette Dental must receive your claim no more than 6 months after the date of service. Claims will not be paid if they are not received on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service.

The date of service is the date you receive the service or supply. You must actually receive the service or supply before your claim can be paid. Your claim will be acknowledged or paid no more than 30 days after it is received.

8.2 APPEALS

Before you file an appeal, call the Member Services Department. They may be able to resolve your problem over the phone.

If you have questions or concerns about a decision, action or statement by a Willamette Dental dentist, you should discuss this with your dentist during the appointment. If you are still not satisfied after the discussion, you may file a first level appeal. Send it to the Member Services Department (see section 2.1).

8.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

a. You have **180 days** from the date you receive an adverse benefit determination to send your first level appeal.
b. You have **60 days** from the date of the first level appeal decision to send your second level appeal.

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see “Filing an Appeal” in Section 12). Describe what happened and what outcome you are hoping for. Include dental records or other documentation that will help us investigate your appeal.

8.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and a second level appeal.

You may review the claim file and submit written comments, documents, records and other information to support your appeal.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time (see section 2.1 for the address). If you need help, ask the Member Services Department.
b. Someone who was not involved in the original decision will investigate your appeal.
c. The network will send the decision to you within 30 days.

Special Circumstances

The timelines for reviewing your appeal do not apply if:

a. You do not reasonably cooperate
b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises.

You must go through the first and second levels of appeal before you sue under ERISA Section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights.

8.2.3 Definitions

For the purposes of section 8.2, the following definitions apply:

Adverse Benefit Determination is a letter or an Explanation of Benefits (EOB) telling you that you are not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Eligibility to participate in the Plan
b. Utilization review
c. Limitations or exclusions described in Section 4 through Section 7, including a decision that an item or service is experimental or investigational or not dentally necessary.

Appeal is a written request by you or your representative for us to review an adverse benefit determination.

Utilization Review is how we or Willamette Dental review the dental necessity, appropriateness or quality of dental care services and supplies. These adverse benefit determinations are examples of utilization review decisions:

a. The care is not dentally necessary or appropriate
b. The care is investigational or experimental
c. The decision about whether a benefit is covered involved a dental judgment

8.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

8.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have dental coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then any other plans pay. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first.

COB can be very complicated. This is a summary of some of the more common situations where you may have double coverage. It is not a full description of the COB rules. If your situation is not described here, contact Customer Service for more information.

8.3.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

a. The subscriber's own dental expenses
b. Your covered child's expenses when you are the subscriber and
    i. Your birthday falls earlier in the year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
    ii. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
    iii. If you are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

8.3.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses.

a. We will calculate the benefits we would have paid if you did not have any other dental coverage. We will apply that amount to any allowable expense that the primary plan did not pay.
b. We will credit any amount to the deductible that would have been applied if you did not have other dental coverage.
c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense.
d. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either. An example is if you have a lower benefit from your primary plan because you did not use an in-network provider

If the primary plan is a closed panel plan (like this Plan) and you use an out-of-network provider, we will provide benefits from a Willamette Dental provider as if we are the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Any plan that does not follow Oregon's COB rules is always primary.

8.3.1.3 Definitions

For purposes of section 8.3.1, the following definitions apply:

Plan is any of the following that provides benefits or services for dental care or treatment:

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

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.

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 does not include:

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

Allowable expense is a dental expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

These are not allowable expenses:

a. Any expense that is not covered by any plan covering you.
b. Any expense a provider is not allowed to charge you.

8.3.2 Third Party Liability

The rules for third party liability, including motor vehicle and other accidents, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

The Plan does not cover benefits when someone else - a third party - is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so Willamette Dental will provide benefits based on the understanding and agreement it is entitled to be reimbursed for any benefits it provided that are or may be recoverable from a third party.

You agree to do whatever is necessary to fully secure and protect our right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. We and Willamette Dental are entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate with us and Willamette Dental to protect our subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect our rights and providing any information or taking any actions that will help us recover costs from a third party. We have discretion to interpret these recovery and subrogation provisions.

a. If we pay claims, or Willamette Dental provides benefits, that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for us and Willamette Dental.

b. We and Willamette Dental are entitled to be reimbursed for any benefits we have provided out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. We and Willamette Dental are entitled to receive the value of benefits we have paid or provided whether the dental expenses are itemized or expressly excluded in the third party recovery.

c. If this Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.

d. Even without your written authorization, we or Willamette Dental may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 8.3.2.

e. If it is reasonable to expect that you will have future expenses for which the Plan might provide benefits, you will seek recovery of such future expenses in any third party claim.

f. Section 8.3.2 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Delta Dental.

If you or your representatives do not comply with the requirements of this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any sickness, illness, injury or dental/medical condition related to the third party claim. We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

8.3.2.1 Motor Vehicle Accidents Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we will advance benefits. We have the right to be repaid from the proceeds of any settlement, judgment or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If we require you or your attorney to protect our recovery rights under this section, then you 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.

You will do whatever is required to secure, and may not prejudice, our rights under this section.

SECTION 9. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

9.1 SUBSCRIBER

You must give the Group a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Your coverage begins on the date specified in the policy. This will be on your enrollment date or after a waiting period. To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You must tell us and the Group if your address changes.

9.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (as defined in Section 11) is eligible for coverage. If a subscriber marries or enters a domestic partnership, the spouse or domestic partner and their children can enroll as of the date of the marriage or partnership. Coverage begins on the first day of the month after your application is received. See section 9.2.1 for more information.

A subscriber's children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26.

In this Plan, eligible children are:

a. The biological or adopted child of the subscriber or the subscriber's eligible spouse or domestic partner
b. Children placed for adoption with the subscriber
c. Your newborn child for the first 31 days of the newborn's life
d. Children related to the subscriber and the subscriber is their legal guardian

Your newborn child is eligible from birth and coverage begins that day. A subscriber's adopted child, or child placed for adoption, is eligible on the date of placement. Their coverage begins on the date of adoption or placement. Court ordered coverage begins on the first day of the month after the date the Group determines that the order qualifies as a QMCSO, and that the child is eligible to enroll in the Plan. You must provide proof of legal guardianship to cover the subscriber's grandchild after the first 31 days from birth. See section 9.2.1 to add your new child.

Children with Disabilities
A subscriber's child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even though they are over 26 years old. If the child is eligible for over-age coverage under the medical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, you must send us the medical carrier's

determination that the child is eligible for over-age coverage at least 45 days before the child's 26th birthday to avoid a break in coverage.

9.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered.

To add a new dependent to your coverage, submit:

a. Complete and signed application
b. Documentation. This may be a marriage certificate, domestic partnership documentation, birth certificate, or guardianship, adoption or placement for adoption paperwork

You must apply within 31 days of the new dependent becoming eligible. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums.

9.3 OPEN ENROLLMENT

If you are not enrolled within 31 days of first becoming eligible, you must wait for the next open enrollment period to enroll unless:

a. You qualify for special enrollment as described in section 9.4
b. A court has ordered that you provide coverage for a spouse or minor child under the subscriber's dental plan. You must enroll no more than 30 days after the court order is issued

Open enrollment occurs once a year at renewal. If you enroll during open enrollment, coverage begins on the date the Plan renews.

9.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

9.4.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other dental coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

a. You stated in writing that you already had dental coverage when this Plan was first offered to you
b. You ask to enroll no more than 31 days after your prior coverage ended
c. You have a qualifying event. These are:

i. Your other coverage ended because you were no longer eligible. Examples of when this happens include:
   A. loss of dependent status per plan terms, including divorce or legal separation
   B. end of employment or not working enough hours
   C. reaching the lifetime maximum on all benefits
   D. the plan stops offering coverage to a specific group of similarly situated persons
   E. moving out of an HMO service area and the plan does not have another option
   F. the benefit packet option is canceled, and no substitute option is offered
ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll.
iii. You exhausted your COBRA continuation coverage

9.4.2 Payment Changes

You may have special enrollment rights when there are changes to how your premiums are paid:

a. Employer contributions toward your active coverage (not COBRA coverage) end.
b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before the premium contribution or subsidy change.

9.4.3 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, domestic partnership, birth, adoption or placement for adoption). You can enroll along with your new dependent. See section 9.2.1.

9.4.4 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in the Plan.

9.5 WHEN COVERAGE ENDS

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

9.5.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends.

9.5.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, only at open enrollment or if there is a qualifying event. Qualifying events including marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

9.5.3 Death

If the subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage if you meet the requirements for continuation of coverage (see Section 10). The Group must tell us your coverage is continued and include your premiums with their regular monthly payment.

9.5.4 Termination, Layoff or Reduction in Hours of Employment

When the subscriber's employment ends, coverage ends on the last day of that month unless you choose to continue coverage (see Section 10).

If you are laid off or your work hours are reduced, coverage ends on the last day of the month you were eligible. You can restart your coverage as if it had never ended if you are back at work and working the required hours within 9 months. Coverage will restart on the date you meet the eligibility requirements.

a. You will not have to re-serve a waiting period
b. The Group must notify us that you have been rehired following a layoff or that your hours have been increased
c. Your premiums must be paid

9.5.5 Willamette Dental Ends Coverage

Your coverage may end if Willamette Dental has documented good cause to stop providing dental care to you, such as an inability to establish or maintain a patient/provider relationship between you and a network dentist at locations reasonably accessible to you. Coverage ends on the last day of the month after we send you a 30-day written notice.

9.5.6 Loss of Eligibility by Dependent

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

a. Coverage ends for an enrolled spouse or domestic partner on the last day of the month in which the marriage or partnership is legally ended (divorce, dissolution, annulment, etc.)
b. Coverage ends for an enrolled child on the last day of the plan year in which
    i. the child reaches age 26
    ii. stepchild relationship ends due to divorce or end of domestic partnership
    iii. legal guardianship ends

You must tell us when a marriage, domestic partnership or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends (see Section 10).

9.5.7 Rescission

Rescission means cancelling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group. Examples of fraud and material misrepresentation include but are not limited to:

a. Enrolling someone who is not eligible
b. Giving false information or withholding information that is the basis for eligibility or employment
c. Submitting false or altered claims

We have the right to keep any premiums paid as liquidated damages. You and/or the Group will have to repay any benefits that have been paid. We will tell you of a rescission 30 days before your coverage is canceled.

9.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including, but not limited to member birth certificates, adoption paperwork, marriage certificates or domestic partnership documentation and any other evidence necessary to document your eligibility for the Plan.

SECTION 10. CONTINUATION OF DENTAL COVERAGE

Check with the Group to find out if you qualify for this continuation coverage. You should read the following sections carefully.

10.1 GENERAL OREGON CONTINUATION

General Oregon Continuation applies to employers who are not required to offer COBRA continuation.

You may request General Oregon Continuation coverage if you lose coverage due to one of the following qualifying events:

a. Subscriber's employment ends or their work hours are reduced
b. Subscriber becomes eligible for Medicare
c. Subscriber dies or marriage/domestic partnership with the subscriber ends
d. Child no longer qualifies as an eligible child under the Plan

You must have been enrolled on the Plan for at least 3 consecutive months before the date of the qualifying event. You cannot be eligible for Medicare or for any other hospital or medical benefits that are not already covering you when the subscriber's employment ended. If you are eligible for 55+ Oregon continuation coverage (see section 10.2), you cannot elect General Oregon Continuation.

You must ask for continuation coverage in writing no more than 10 business days after you receive the notice of your continuation rights or after the date of the qualifying event, whichever is later. If you do not ask for General Oregon Continuation on time or pay your first premium within 31 days of the date coverage normally would have ended, your coverage under the Plan will end.

General Oregon Continuation will end if we do not receive your premiums on time or if the Plan as a whole ends. Otherwise, coverage ends on the earliest of the following events:

a. 9 months after the date on which coverage under the Plan otherwise would have ended
b. You becomes eligible for other dental coverage or for Medicare
c. You give us written notice that you want to end your coverage

10.2 55+ OREGON CONTINUATION

55+ Oregon Continuation applies to employers with 20 or more employees. It provides continuation coverage for spouses and domestic partners age 55 and older at the time of such event who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended, you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the following requirements.

You must notify the Group or its third party administrator within 60 days from the date your marriage or domestic partnership is legally ended or within 30 days after the subscriber has died.

Include your mailing address. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise, 55+ Oregon Continuation ends when you become insured under any other group dental plan, you become eligible for Medicare or you remarry or register another domestic partnership.

If the Group or its third party administrator does not notify you of your continuation rights, the Group is responsible for premiums from the date the notice was required until the date you receive the notice.

10.3 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g., divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA. You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand delivered). The premium rate may include a 2% add-on to cover administrative expenses. All other payments are

due on the 1st day of the month. You will not receive a bill. You are responsible for paying your premiums when due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of the subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period. You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 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 you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premiums. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

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 10.2).

When COBRA Ends
COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group dental plan to its employees. COBRA will also end if:

a. You become covered under another group dental plan
b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Do not forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**
A domestic partner does not have an independent election right under COBRA. If you are a covered domestic partner at the time of the qualifying event, the subscriber can include coverage for you when they elect COBRA. Your coverage ends when the subscriber's COBRA coverage ends (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

10.4 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If a subscriber does not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

10.5 FAMILY & MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will restart as if there had been no break in coverage.

10.6 STRIKE OR LOCKOUT

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Group, to the union or trust. The union or trust must send the premiums to us when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. You become employed full-time with another employer
c. You lose eligibility under the Plan for other reasons

SECTION 11. DEFINITIONS

Benefits means the covered services that are available under the terms of the Plan.

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.

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

Coinsurance is a percentage of covered expenses that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and we pay the other 80%.

Copay or **Copayment** is the fixed dollar amount you pay to a provider when you get a covered service. The copays you must pay for services under the Plan are listed in Section 13. Other than service charges, this is the only amount you must pay a Willamette Dental dentist for a covered service.

Cost Sharing is the share of costs you must pay when you get a covered service. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network emergencies or the cost of non-covered services.

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. Where this book refers to “we”, “us” or “our” it is referring to Delta Dental or its employees.

Dentally Necessary means services that:

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

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

Dentist is a licensed dentist, operating within the scope of their license.

Denture Repair is a procedure 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 is any person who is or may become eligible for coverage under the terms of the Plan because of their relationship to the subscriber.

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

Eligible Employee means an employee of the Group who meets the eligibility requirements to be enrolled on the Plan.

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

Enrollment Date is, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

The **Group** is the organization whose employees are covered by the Plan.

Group Health Plan is 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 plan is a group health plan.

Investigational Service or Supply is a service or supply (including equipment, drugs, devices and other items) that the network determines meet one of the following:

a. is classified by the network as experimental or investigational
b. is under continued scientific testing and research because it has not yet been proven to show a demonstrable benefit for a particular condition, or to be safe and effective
c. is on an investigational protocol, unless approved in writing in advance by the network

Member is the subscriber or dependent of the subscriber who has enrolled for coverage under the terms of the Plan. Where this book refers to “you” or “your” it is referring to a member.

Network is Willamette Dental, the exclusive provider group that provides dental care to you.

Network Dentist is a licensed dentist who is employed by or is under contract with Willamette Dental or any of its affiliates to provide dental services to you.

Network Provider is a licensed dentist, licensed denturist or licensed hygienist who is employed by or is under contract with Willamette Dental or any of its affiliates to provide dental services to you.

Outside Dentist or Specialist is a licensed dentist who is not employed by or under contract with Willamette Dental.

Periodontal Maintenance is a periodontal procedure done when you have been treated for periodontal disease. This is a more comprehensive service than a regular cleaning (prophylaxis), where surfaces below the gum-line are also cleaned.

The **Plan** is the dental benefit plan sponsored by the Group and insured under the terms of the policy between the Group and Delta Dental.

Policy is the agreement between the Group and Delta Dental for insuring the dental benefit plan sponsored by the Group. This handbook is a part of the policy.

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

Prophylaxis is cleaning and polishing the visible surfaces of all teeth.

Reasonable Cash Value is the total fee for each service or supply that Willamette Dental files with Delta Dental.

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

Restoration is treatment that repairs a broken or decayed tooth. Restorations include fillings and crowns.

Service Charge is a charge for a late cancellation of an appointment, for missing an appointment and/or a delinquent account charge.

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

Waiting Period is the period that must pass before you are eligible to enroll for benefits under the terms of the Plan.

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

12.1 MISCELLANEOUS PROVISIONS

Contract Provisions
The policy between Delta Dental and the Group and 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 policy plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims and medical and dental information. We use this information to pay your claims. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how we use your PHI. Follow the Privacy Center link on the Delta Dental website for a copy of this notice, or call 855-425-4192.

Right to Collect & Release Needed Information
You must give or authorize a provider to give us or Willamette Dental any information we need to provide benefits. We or Willamette Dental may release to or collect from any person or organization any needed information about you.

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.

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.

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.

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 we delay or fail to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive Delta Dental's rights to enforce the provisions of the Plan.

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.

Responsibility for Quality of Care
You have the right to choose your dental provider (although this Plan only covers the services of Willamette Dental providers). Neither the Plan nor Delta Dental is responsible for the quality of your care. Delta Dental and Willamette Dental dentists are independent contractors. A dentist is solely responsible for the dental care provided to you. Delta Dental does not control the detail, manner or methods by which any dentist, including a Willamette Dental dentist, provides care. Neither the Plan nor Delta Dental can be held liable for the negligence of any dentist providing services to you.

Provider Reimbursement
Willamette Dental dentists agree that they will accept fees in the amount established by Willamette Dental as full payment for their services. You must pay the copayments, service charges and for any non-covered services. Willamette Dental dentists will not charge you more for covered services than the copayment amounts listed in Section 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.

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.

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

Notices
Any notice to you, to a provider or to the Group that we are required to provide is considered properly given if written notice is deposited in the U.S. mail or with a private carrier. Notices will be addressed to the last known address in our records. If we receive a U.S. Postal Service change of address form, we will update our records with that new address. We may forward a notice for you to the Group if we become aware that we do not have a valid mailing address for you. Any notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

Filing an Appeal
You can file an appeal or complaint by writing a letter to Moda Health. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Dental records from the provider, if applicable
g. Reason for the appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in 8.2.

12.2 ERISA Duties

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Ask the Group if this section applies to your Plan.

Plan Administrator as Defined Under ERISA
Delta Dental is not the plan administrator or the named fiduciary of the Plan, as defined under ERISA. Contact the Group for more information.

Information About the Plan and Benefits
Subscribers may examine all documents governing the Plan. This includes insurance contracts, collective bargaining agreements, updated summary plan description and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. You can get this information by requesting it in writing. You will not be charged, except the Group may charge a reasonable amount for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA.

Continuation of Group Dental Plan Coverage
Subscribers are entitled to continue dental care coverage for themselves or their dependents if they lose coverage under the Plan because of a qualifying event. You may have to pay for such coverage. Review this handbook and the documents governing the Plan for information about the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent the subscriber from obtaining a benefit or exercising rights under ERISA.

Enforcement of Rights
If a claim for benefits is denied or no action is taken, in whole or in part, you have a right to receive an explanation, to obtain without charge copies of documents relating to the decision and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you ask the Group for a copy of plan documents or the latest annual report and do not receive it within 30 days, you may file suit in federal court. The court may require the Group to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Group's control. If a claim for benefits is denied or no action is taken, you may file suit in state or federal court after you have exhausted the Plan's appeal process (see section 8.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

Assistance with Questions
For questions about this section or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

Employee Benefits Security Administration
Seattle District Office, 300 Fifth Ave., Ste. 1110, Seattle, WA 98104
206-757-6781
Information and assistance are also available through their website: dol.gov/agencies/ebsa.

Office of Outreach, Education and Assistance,
US Department of Labor
200 Constitution Ave. NW, Washington DC, 20210
866-444-3272
You may call them to obtain publications about your rights and responsibilities under ERISA

SECTION 13. SCHEDULE OF COVERED SERVICES & COPAYMENTS

You must pay the General Office Visit Charge copayment or the Specialist Office Visit Charge copayment at each visit. You may also have to pay a separate, additional copayment for covered services as shown below. Copayments are due at the time of service.

FOR MEMBERS AGE 19 AND OLDER

CDT Code	Procedure	Copay
13.1	**General Office Visit Charge**	$15
	Specialist Office Visit Charge	$30
13.2	**Diagnostic and Preventive Services**	
D0120	Periodic oral evaluation – established patient	No Copay
D0140	Limited oral evaluation – problem focused	No Copay
D0150	Comprehensive oral evaluation - new or established patient	No Copay
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Copay
D0170	Re-evaluation – limited problem focused (established patient; not post-operative visit)	No Copay
D0180	Comprehensive periodontal evaluation – new or established patient	No Copay
D0210	Intraoral – complete series of radiographic images	No Copay
D0220	Intraoral - Periapical – first radiographic image	No Copay
D0230	Intraoral - Periapical – each additional radiographic image	No Copay
D0240	Intraoral – occlusal radiographic image	No Copay
D0250	Extraoral – 2D projection radiographic image	No Copay
D0270	Bitewing – single radiographic image	No Copay
D0272	Bitewings –2 radiographic images	No Copay
D0273	Bitewings – 3 radiographic images	No Copay
D0274	Bitewings – 4 radiographic images	No Copay
D0277	Vertical bitewings – 7 to 8 radiographic images	No Copay
D0330	Panoramic radiographic images	No Copay
D0340	2D Cephalometric radiographic image	No Copay
D0350	2D Oral/facial photographic image obtained intraorally or extraorally	No Copay
D0425	Caries susceptibility tests	No Copay
D0460	Pulp vitality tests	No Copay
D0470	Diagnostic casts	No Copay
D1110	Teeth cleaning (prophylaxis) – adult	No Copay
D1206	Topical application of fluoride varnish	No Copay
D1208	Topical application of fluoride – excluding varnish	No Copay
D1310	Nutritional counseling for control of dental disease	No Copay
D1320	Tobacco counseling for control and prevention of oral disease	No Copay

CDT Code	Procedure	Copay
D1330	Oral hygiene instructions	No Copay
D1351	Sealant – per tooth	No Copay
D1354	Application of caries arresting medicament – per tooth	No Copay
D1355	Caries preventative medicament application – per tooth	No Copay
13.3	**Space Maintainers**	
D1510	Space maintainer – fixed unilateral – per quadrant	No Copay
D1516	Space maintainer – fixed bilateral, maxillary	No Copay
D1517	Space maintainer – fixed bilateral, mandibular	No Copay
D1520	Space maintainer – removable unilateral – per quadrant	No Copay
D1526	Space maintainer – removeable bilateral, maxillary	No Copay
D1527	Space maintainer – removable bilateral, mandibular	No Copay
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Copay
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Copay
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Copay
D1556	Removal of fixed unilateral space maintainer – per quadrant	No Copay
D1557	Removal of fixed bilateral space maintainer - maxillary	No Copay
D1558	Removal of fixed bilateral space maintainer – mandibular	No Copay
13.4	**Restorative Dentistry**	
	a. Amalgam Restorations	
D2140	Fillings – 1 surface, primary or permanent	$15
D2150	Fillings – 2 surfaces, primary or permanent	$15
D2160	Fillings – 3 surfaces, primary or permanent	$15
D2161	Fillings – 4 or more surfaces, primary or permanent	$15
	b. Resin-based Composite Restorations	
D2330	Resin – 1 surface (anterior only)	$15
D2331	Resin – 2 surfaces (anterior only)	$15
D2332	Resin – 3 surfaces (anterior only)	$15
D2335	Resin – 4 or more surfaces (anterior)	$15
D2390	Resin-based composite crown (anterior)	$15
D2391	Resin – 1 surface, posterior	$15
D2392	Resin – 2 surfaces, posterior	$15
D2393	Resin – 3 surfaces, posterior	$15
D2394	Resin – 4 or more surfaces, posterior	$15
	c. Inlay/Onlay (cast restorations)	
D2510	Inlay – metallic, 1 surface	$375
D2520	Inlay – metallic, 2 surfaces	$375
D2530	Inlay – metallic, 3 or more surfaces	$375
D2542	Onlay – metallic, 2 surfaces	$375
D2543	Onlay – metallic, 3 surfaces	$375
D2544	Onlay – metallic, 4 or more surfaces	$375
D2610	Inlay – porcelain/ceramic – 1 surface	$375
D2620	Inlay – porcelain/ceramic – 2 surfaces	$375
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	$375
D2642	Onlay – porcelain/ceramic – 2 surfaces	$375

CDT Code	Procedure	Copay
D2643	Onlay – porcelain/ceramic – 3 surfaces	$375
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	$375
13.5 Crowns		
D2710	Crown – resin-based composite (indirect)	$375
D2740	Crown – porcelain/ceramic	$375
D2750	Crown – porcelain fused to high noble metal	$375
D2780	Crown – ¾ cast high noble metal	$375
D2782	Crown - ¾ cast noble metal	$375
D2790	Crown - full cast high noble metal	$375
D2792	Crown - full cast noble metal	$375
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	No Copay
D2920	Re-cement or re-bond crown	No Copay
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	No Copay
D2929	Prefabricated porcelain/ceramic crown – primary tooth	No Copay
D2930	Prefabricated stainless steel crown – primary	No Copay
D2931	Prefabricated stainless steel crown – permanent	No Copay
D2932	Prefabricated resin crown	No Copay
D2933	Prefabricated stainless steel crown with resin window	No Copay
D2940	Protective restoration	No Copay
D2950	Core buildup, including any pins when required	No Copay
D2951	Pin retention – per tooth, in addition to restoration	No Copay
D2954	Prefabricated post and core in addition to crown	No Copay
D2955	Post removal	No Copay
D2957	Each additional prefabricated post – same tooth	No Copay
D2975	Coping	No Copay
D2980	Repair crown (necessitated by restorative material failure)	No Copay
13.6 Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	No Copay
D3120	Pulp cap – indirect (excluding final restoration)	No Copay
D3220	Therapeutic Pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament - A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	No Copay
D3221	Pulpal debridement, primary and permanent teeth	No Copay
D3230	Pulpal therapy – (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Copay
D3240	Pulpal therapy – (resorbable filing) – posterior, primary tooth (excluding final restoration)	No Copay
D3310	Endontic (root canal) therapy – anterior tooth (excluding final restoration)	$125
D3320	Endontic (root canal) therapy – premolar tooth (excluding final restoration)	$200
D3330	Endontic (root canal) therapy – molar (excluding final restoration)	$250
D3331	Treatment of root canal obstruction – non-surgical access	No Copay

CDT Code	Procedure	Copay
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	No Copay
D3333	Internal repair of perforation defects	No Copay
D3346	Retreatment of previous root canal therapy – anterior	$125
D3347	Retreatment of previous root canal therapy – premolar	$200
D3348	Retreatment of previous root canal therapy – molar	$250
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$250
D3352	Apexification/recalcification – interim medication replacement	No Copay
D3353	Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	No Copay
D3410	Apicoectomy/recalcification – anterior	$125
D3421	Apicoectomy/recalcification – premolar (1st root)	$200
D3425	Apicoectomy/recalcification – molar (1st root)	$250
D3426	Apicoectomy/recalcification – (each additional root)	No Copay
D3430	Retrograde filling – per root	No Copay
D3450	Root amputation per root	$250
D3911	Intraorifice barrier	$15
D3920	Hemisection (including any root removal), not including root canal therapy	$250
D3921	Decoronation or submergence of an erupted tooth	$125
D3950	Canal preparation and fitting of a preformed dowel or post	No Copay
13.7 Periodontics		
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant	$175
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$100
D4240	Gingival flap procedure – 4 or more contiguous teeth or tooth bounded spaces per quadrant	$175
D4241	Gingival flap procedure – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$175
D4249	Clinical Crown lengthening – hard tissue	$175
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – 4 or more contiguous teeth or toothbounded spaces per quadrant	$175
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – 1 to 3 contiguous teeth or toothbounded spaces per quadrant	$175
D4263	Bone replacement graft – retained natural tooth - 1st site in quadrant	No Copay
D4264	Bone replacement graft – retained natural tooth - each additional site in quadrant	No Copay
D4270	Pedicle soft tissue graft procedure	$175
D4273	Autogenous connective graft procedure (including donor and recipient surgical sites) first tooth	$175

CDT Code	Procedure	Copay
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$175
D4277	Free soft tissue graft procedure, (including recipient and donor surgical sites), 1st tooth or edentulous tooth position in graft	$175
D4278	Free soft tissue graft procedure, (including recipient and donor surgical sites), each additional tooth or edentulous tooth position in graft stie	$175
D4283	Autogenous connective tissue graft procedure each additional contiguous tooth or edentulous tooth position in the same graft site	$175
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$100
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	$100
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	No Copay
D4355	Full-mouth debridement enable a comprehensive oral evaluation and diagnosis on a subsequent visit	No Copay
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	No Copay
D4910	Periodontic maintenance	No Copay
13.8 Prosthodontics - Removable		
D5110	Complete (denture) - maxillary	$500
D5120	Complete (denture) - mandibular	$500
D5130	Immediate (denture) - maxillary	$500
D5140	Immediate (denture) - mandibular	$500
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$500
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$500
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$500
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$500
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	$500
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	$500
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	$500

CDT Code	Procedure	Copay
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant	$500
D5410	Adjustment – complete denture, maxillary	No Copay
D5411	Adjustment – complete denture, mandibular	No Copay
D5421	Adjustment – partial denture, maxillary	No Copay
D5422	Adjustment – partial denture, mandibular	No Copay
D5511	Repair broken complete denture base, mandibular	No Copay
D5512	Repair broken complete denture base, maxillary	No Copay
D5520	Repair denture replace missing or broken teeth (each tooth)	No Copay
D5611	Repair resin partial denture base, mandibular	No Copay
D5612	Repair resin partial denture base, maxillary	No Copay
D5621	Repair cast partial framework, mandibular	No Copay
D5622	Repair cast partial framework, maxillary	No Copay
D5630	Repair or replace broken retentive/clasping materials – per tooth	No Copay
D5640	Replace broken teeth – per tooth	No Copay
D5650	Add tooth to existing partial denture	No Copay
D5660	Add clasp to existing partial denture – per tooth	No Copay
D5670	Replace all teeth and acrylic on cast metal framework - maxillary	No Copay
D5671	Replace all teeth and acrylic on cast metal framework - mandibular	No Copay
D5710	Rebase complete maxillary denture	No Copay
D5711	Rebase complete mandibular denture	No Copay
D5720	Rebase maxillary partial denture	No Copay
D5721	Rebase mandibular partial denture	No Copay
D5730	Reline complete maxillary denture (direct)	No Copay
D5731	Reline complete mandibular denture (direct)	No Copay
D5740	Reline maxillary partial denture (direct)	No Copay
D5741	Reline mandibular partial denture (direct)	No Copay
D5750	Reline complete maxillary denture (indirect)	No Copay
D5751	Reline complete mandibular denture (indirect)	No Copay
D5760	Reline maxillary partial denture (indirect)	No Copay
D5761	Reline mandibular partial denture (indirect)	No Copay
D5765	Soft liner for complete or partial removable denture (indirect)	No Copay
D5810	Interim complete denture – maxillary	$250
D5811	Interim complete denture – mandibular	$250
D5820	Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	$250
D5821	Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	$250
D5850	Tissue conditioning – maxillary	No Copay
D5851	Tissue conditioning – mandibular	No Copay
D5863	Overdenture – complete maxillary	$500
D5864	Overdenture – partial maxillary	$500
D5865	Overdenture – complete mandibular	$500
D5866	Overdenture – partial mandibular	$500
D5986	Fluoride gel carrier	No Copay

CDT Code	Procedure	Copay
13.9	**Prosthodontics – Fixed**	
D6210	Pontic – cast high noble metal	$375
D6240	Pontic – porcelain fused to high noble metal	$375
D6241	Pontic – porcelain fused to predominantly base metal	$375
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$375
D6720	Retainer crown – resin with high noble metal	$375
D6750	Retainer crown – porcelain fused to high noble metal	$375
D6780	Retainer crown – ¾ cast high noble metal	$375
D6790	Retainer crown – full cast high noble metal	$375
D6930	Re-cement or re-bond fixed partial denture	No Copay
D6980	Fixed partial denture repair necessitated by restorative material failure	No Copay
13.10	**Oral Surgery**	
D7111	Extraction, coronal remnants – primary tooth	$15
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Extraction - erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$175
D7220	Removal of impacted tooth – soft tissue	$175
D7230	Removal of impacted tooth – partially bony	$175
D7240	Removal of impacted tooth – completely bony	$175
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$175
D7260	Oroantral fistula closure	$175
D7261	Primary closure of sinus perforation	$175
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$175
D7280	Exposure of an unerupted tooth	$175
D7283	Placement of device to facilitate eruption of impacted tooth ortho bracket to aid eruption (if Plan covers orthodontia)	$175
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$175
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth per quadrant	No Copay
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant	No Copay
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth per quadrant	No Copay
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant	No Copay
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$175

CDT Code	Procedure	Copay
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$175
D7471	Removal of lateral exostosis (maxilla or mandible)	$175
D7472	Removal of torus palatinus	$175
D7473	Removal of torus mandibularis	$175
D7510	Incision and drainage of abscess – intraoral soft tissue	No Copay
D7520	Incision and drainage of abscess – extraoral soft tissue	No Copay
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	No Copay
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	No Copay
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	No Copay
D7670	Alveolus – closed reduction, may include stabilization of teeth	No Copay
D7910	Suture of recent small wound up to 5 cm	No Copay
D7911	Complicated suture – up to 5 cm	No Copay
D7953	Bone replacement graft for ridge preservation – per site	$175
D7961	Buccal/labial frenectomy (frenulectomy)	$175
D7970	Excision of hyperplastic tissue per arch	$175
D7971	Excision of pericoronal gingiva	$175
13.11 Anesthesia		
D9222	Deep sedation/General anesthesia – 1st 15 minutes	Not Covered
D9223	Deep sedation/General anesthesia – each additional 15 minutes	Not Covered
D9230	Inhalation of nitrous oxide analgesia, anxiolysis (per visit)	$40
13.12 Miscellaneous		
D9110	Palliative (emergency) treatment of dental pain – per visit	No Copay
D9120	Fixed partial denture sectioning	No Copay
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	No Copay
D9420	Hospital or ambulatory surgical center call (dental treatment provided in a hospital setting; facility fees not covered; other applicable service copays still apply)	$100
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Copay
D9440	Emergency treatment – after office hours	$25
D9910	Application of desensitizing medicament	No Copay
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	No Copay
D9951	Occlusal adjustment - limited	No Copay
D9952	Occlusal adjustment - complete	No Copay
D9970	Enamel microabrasion	No Copay
	Out-of-area emergency reimbursement (You will be reimbursed up to $100 for covered services)	Charges over $100

CDT Code	Procedure	Copay
13.13 Orthodontia		
	Comprehensive orthodontia treatment	$2,200
D8660	Pre orthodontic treatment services	
	Initial orthodontic exam	$25
	Study models and x-rays	$125
	Case presentation	No Copay
13.14 Dental Implants		
	Dental Implant Surgery. The following dental implant services are covered at 100%, **up to an annual dental implant benefit maximum of $1,500**. The annual dental implant benefit maximum is the maximum dollar amount covered for the below dental implant services in a calendar year.	
D6010	Surgical placement of implant body: endosteal implant	
D6011	Second stage implant surgery	
13.15 Exclusions		
	See Section 7	

FOR MEMBERS UNDER AGE 19*

*These pediatric benefits apply until the end of the month in which you turn age 19.

Out of Pocket Limit $450 to maximum of $900 per family

CDT Code	Procedure	Copay
13.16 General Office Visit Charge		$15
Specialist Office Visit Charge		$30
13.17 Diagnostic and Preventive Services		
D0120	Periodic oral evaluation – established patient	No Copay
D0140	Limited oral evaluation – problem focused	No Copay
D0145	Oral Evaluation – patient under 3 years and counseling with primary caregiver	No Copay
D0150	Comprehensive oral evaluation – new or established patient	No Copay
D0160	Detailed and extensive oral evaluation – problem focused	No Copay
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	No Copay
D0180	Comprehensive periodontal evaluation – new or established patient	No Copay
D0191	Assessment of a patient	No Copay
D0210	Intraoral – complete series x-rays or radiographic images	No Copay
D0220	Intraoral - Periapical – first radiographic image	No Copay
D0230	Intraoral - Periapical – each additional radiographic image	No Copay
D0240	Intraoral – occlusal radiographic image	No Copay

CDT Code	Procedure	Copay
D0250	Extraoral – 2D projection radiographic image	No Copay
D0270	Bitewing – single radiographic image	No Copay
D0272	Bitewings – 2 radiographic images	No Copay
D0273	Bitewings – 3 radiographic images	No Copay
D0274	Bitewings – 4 radiographic images	No Copay
D0277	Vertical bitewings – 7 to 8 radiographic images	No Copay
D0330	Panoramic radiographic image	No Copay
D0340	2D Cephalometric radiographic image	No Copay
D0350	2D Oral/facial photographic image obtained intraorally or extraorally	No Copay
D0415	Collection of microorganisms for culture and sensitivity	No Copay
D0425	Caries susceptibility tests	No Copay
D0460	Pulp vitality tests	No Copay
D0470	Diagnostic casts	No Copay
D1110	Teeth cleaning (prophylaxis) – adult	No Copay
D1120	Teeth cleaning (prophylaxis) – child	No Copay
D1206	Topical application of fluoride varnish	No Copay
D1208	Topical application of fluoride – excluding varnish	No Copay
D1310	Nutritional counseling for control of dental disease	No Copay
D1320	Tobacco counseling for control and prevention of oral disease	No Copay
D1330	Oral hygiene instructions	No Copay
D1351	Sealant – per tooth	No Copay
D1354	Application of caries arresting medicament – per tooth	No Copay
D1355	Caries preventative medicament application – per tooth	No Copay
13.18 Space Maintainers		
D1510	Space maintainer – fixed unilateral – per quadrant	No Copay
D1516	Space maintainer – fixed bilateral, maxillary	No Copay
D1517	Space maintainer – fixed bilateral, mandibular	No Copay
D1520	Space maintainer – removable unilateral – per quadrant	No Copay
D1526	Space maintainer – removable bilateral, maxillary	No Copay
D1527	Space maintainer – removable bilateral, mandibular	No Copay
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Copay
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Copay
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Copay
D1556	Removal of fixed unilateral space maintainer – per quadrant	No Copay
D1557	Removal of fixed bilateral space maintainer - maxillary	No Copay
D1558	Removal of fixed bilateral space maintainer – mandibular	No Copay
13.19 Restorative Dentistry		
a. Amalgam Restorations		
D2140	Fillings – 1 surface, primary or permanent	$15
D2150	Fillings – 2 surfaces, primary or permanent	$15
D2160	Fillings – 3 surfaces, primary or permanent	$15
D2161	Fillings – 4 or more surfaces, primary or permanent	$15
b. Resin-based Composite Restorations		

CDT Code	Procedure	Copay
D2330	Resin – 1 surface (anterior only)	$15
D2331	Resin – 2 surfaces (anterior only)	$15
D2332	Resin – 3 surfaces (anterior only)	$15
D2335	Resin – 4 or more surfaces (anterior)	$15
D2390	Resin-based composite crown (anterior)	$15
D2391	Resin – 1 surface, posterior	$15
D2392	Resin – 2 surfaces, posterior	$15
D2393	Resin – 3 surfaces, posterior	$15
D2394	Resin – 4 or more surfaces, posterior	$15
c.	Inlay/Onlay (cast restorations)	
D2510	Inlay – metallic, 1 surface	$375
D2520	Inlay – metallic, 2 surfaces	$375
D2530	Inlay – metallic, 3 or more surfaces	$375
D2542	Onlay – metallic, 2 surfaces	$375
D2543	Onlay – metallic, 3 surfaces	$375
D2544	Onlay – metallic, 4 or more surfaces	$375
D2610	Inlay – porcelain/ceramic – 1 surface	$375
D2620	Inlay – porcelain/ceramic – 2 surfaces	$375
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	$375
D2642	Onlay – porcelain/ceramic – 2 surfaces	$375
D2643	Onlay – porcelain/ceramic – 3 surfaces	$375
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	$375
13.20	**Crowns**	
D2710	Crown – resin-based composite (indirect)	$375
D2740	Crown – porcelain/ceramic	$375
D2750	Crown – porcelain fused to high noble metal	$375
D2752	Crown - porcelain fused to noble metal	$375
D2780	Crown – ¾ cast high noble metal	$375
D2782	Crown - ¾ cast noble metal	$375
D2790	Crown - full cast high noble metal	$375
D2792	Crown - full cast noble metal	$375
D2799	Interim crown	No Copay
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	No Copay
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Copay
D2920	Re-cement or re-bond crown	No Copay
D2921	Reattachment of tooth fragment	No Copay
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	No Copay
D2929	Prefabricated porcelain/ceramic crown – primary tooth	No Copay
D2930	Prefabricated stainless steel crown – primary	No Copay
D2931	Prefabricated stainless steel crown – permanent	No Copay
D2932	Prefabricated resin crown	No Copay
D2933	Prefabricated stainless steel crown with resin window	No Copay
D2940	Protective restoration	No Copay
D2941	Interim therapeutic restoration – primary dentition	No Copay

CDT Code	Procedure	Copay
D2950	Core buildup, including any pins when required	No Copay
D2951	Pin retention – per tooth, in addition to restoration	No Copay
D2954	Prefabricated post and core in addition to crown	No Copay
D2955	Post removal	No Copay
D2957	Each additional prefabricated post – same tooth	No Copay
D2975	Coping	No Copay
D2980	Repair crown (necessitated by restorative material failure)	No Copay
13.21 Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	No Copay
D3120	Pulp cap – indirect (excluding final restoration)	No Copay
D3220	Therapeutic Pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament - A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	No Copay
D3221	Pulpal debridement, primary and permanent teeth	No Copay
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	No Copay
D3230	Pulpal therapy – (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Copay
D3240	Pulpal therapy – (resorbable filing) – posterior, primary tooth (excluding final restoration)	No Copay
D3310	Endontic (root canal) therapy – anterior tooth (excluding final restoration)	$125
D3320	Endontic (root canal) therapy – premolar tooth (excluding final restoration)	$200
D3330	Endontic (root canal) therapy – molar (excluding final restoration)	$250
D3331	Treatment of root canal obstruction – non-surgical access	No Copay
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	No Copay
D3333	Internal repair of perforation defects	No Copay
D3346	Retreatment of previous root canal therapy – anterior	$125
D3347	Retreatment of previous root canal therapy – premolar	$200
D3348	Retreatment of previous root canal therapy – molar	$250
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$250
D3352	Apexification/recalcification – interim medication replacement	No Copay
D3353	Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	No Copay
D3355	Pulpal regeneration – initial visit	No Copay
D3356	Pulpal regeneration – interim medication replacement	No Copay
D3357	Pulpal regeneration – completion of treatment	No Copay
D3410	Apicoectomy/recalcification – anterior	$125
D3421	Apicoectomy/recalcification – premolar (1st root)	$200
D3425	Apicoectomy/recalcification – molar (1st root)	$250
D3426	Apicoectomy/recalcification – (each additional root)	No Copay

CDT Code	Procedure	Copay
D3430	Retrograde filling – per root	No Copay
D3450	Root amputation per root	$250
D3911	Intraorifice barrier	$15
D3920	Hemisection (including any root removal), not including root canal therapy	$250
D3921	Decoronation or submergence of an erupted tooth	$125
D3950	Canal preparation and fitting of a preformed dowel or post	No Copay
13.22 Periodontics		
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or toothbounded spaces per quadrant	$175
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or toothbounded spaces per quadrant	$100
D4240	Gingival flap procedure – 4 or more contiguous teeth or toothbounded spaces per quadrant	$175
D4241	Gingival flap procedure – 1 to 3 contiguous teeth or toothbounded spaces per quadrant	$175
D4249	Clinical Crown lengthening – hard tissue	$175
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – 4 or more contiguous teeth or toothbounded spaces per quadrant	$175
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – 1 to 3 contiguous teeth or toothbounded spaces per quadrant	$175
D4263	Bone replacement graft – retained natural tooth - 1st site in quadrant	No Copay
D4264	Bone replacement graft – retained natural tooth - each additional site in quadrant	No Copay
D4270	Pedicle soft tissue graft procedure	$175
D4273	Autogenous connective graft procedure (including donor and recipient surgical sites) first tooth	$175
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$175
D4277	Free soft tissue graft procedure, (including recipient and donor surgical sites), 1st tooth or edentulous tooth position in graft	$175
D4278	Free soft tissue graft procedure, (including recipient and donor surgical sites), each additional tooth or edentulous tooth position in graft site	$175
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional continuous tooth or edentulous tooth position in the same graft site	$175
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$100
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	$100

CDT Code	Procedure	Copay
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	No Copay
D4355	Full-mouth debridement enable a comprehensive oral evaluation and diagnosis on a subsequent visit	No Copay
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	No Copay
D4910	Periodontic maintenance	No Copay
13.23 Prosthodontics - Removable		
D5110	Complete (denture) – maxillary	$450
D5120	Complete (denture) – mandibular	$450
D5130	Immediate (denture) – maxillary	$450
D5140	Immediate (denture) – mandibular	$450
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$450
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$450
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$450
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$450
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	$450
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	$450
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	$450
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant	$450
D5410	Adjustment – complete denture, maxillary	No Copay
D5411	Adjustment – complete denture, mandibular	No Copay
D5421	Adjustment – partial denture, maxillary	No Copay
D5422	Adjustment – partial denture, mandibular	No Copay
D5511	Repair broken complete denture base, mandibular	No Copay
D5512	Repair broken complete denture base, maxillary	No Copay
D5520	Repair denture replace missing or broken teeth (each tooth)	No Copay
D5611	Repair resin partial denture base, mandibular	No Copay
D5612	Repair resin partial denture base, maxillary	No Copay
D5621	Repair cast partial framework, mandibular	No Copay
D5622	Repair cast partial framework, maxillary	No Copay
D5630	Repair or replace broken retentive/clasping materials – per tooth	No Copay
D5640	Replace broken teeth – per tooth	No Copay

CDT Code	Procedure	Copay
D5650	Add tooth to existing partial denture	No Copay
D5660	Add clasp to existing partial denture – per tooth	No Copay
D5670	Replace all teeth and acrylic on cast metal framework - maxillary	No Copay
D5671	Replace all teeth and acrylic on cast metal framework - mandibular	No Copay
D5710	Rebase complete maxillary denture	No Copay
D5711	Rebase complete mandibular denture	No Copay
D5720	Rebase maxillary partial denture	No Copay
D5721	Rebase mandibular partial denture	No Copay
D5730	Reline complete maxillary denture (direct)	No Copay
D5731	Reline complete mandibular denture (direct)	No Copay
D5740	Reline maxillary partial denture (direct)	No Copay
D5741	Reline mandibular partial denture (direct)	No Copay
D5750	Reline maxillary denture (indirect)	No Copay
D5751	Reline mandibular denture (indirect)	No Copay
D5760	Reline maxillary partial denture (indirect)	No Copay
D5761	Reline mandibular partial denture (indirect)	No Copay
D5765	Soft liner for complete or partial removable denture (indirect)	No Copay
D5810	Interim denture – maxillary	$250
D5811	Interim denture – mandibular	$250
D5820	Interim partial denture - maxillary	$250
D5821	Interim partial denture – (including retentive/clasping materials, rests and teeth), mandibular	$250
D5850	Tissue conditioning – maxillary	No Copay
D5851	Tissue conditioning – mandibular	No Copay
D5863	Overdenture – complete maxillary	$450
D5864	Overdenture – partial maxillary	$450
D5865	Overdenture – complete mandibular	$450
D5866	Overdenture – partial mandibular	$450
D5986	Fluoride gel carrier	No Copay
13.24 Prosthodontics - Fixed		
D6210	Pontic – cast high noble metal	$375
D6240	Pontic - porcelain fused to high noble metal	$375
D6241	Pontic – porcelain fused to predominantly base metal	$375
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$375
D6720	Retainer crown – resin with high noble metal	$375
D6750	Retainer crown – porcelain fused to high noble metal	$375
D6780	Retainer crown – ¾ cast high noble metal	$375
D6790	Retainer crown – full cast high noble metal	$375
D6930	Re-cement or re-bond fixed partial denture	No Copay
D6980	Fixed partial denture repair necessitated by restorative material failure	No Copay
13.25 Oral Surgery		
D7111	Extraction, coronal remnants – primary tooth	$15

CDT Code	Procedure	Copay
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Extraction - erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$175
D7220	Removal of impacted tooth – soft tissue	$175
D7230	Removal of impacted tooth – partially bony	$175
D7240	Removal of impacted tooth – completely bony	$175
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$175
D7251	Coronectomy intentional partial tooth removal, impacted teeth only	$175
D7260	Oroantral fistula closure	$175
D7261	Primary closure of sinus perforation	$175
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$175
D7280	Exposure of an unerupted tooth	$175
D7283	Placement of device to facilitate eruption of impacted tooth ortho bracket to aid eruption (if Plan covers orthodontia)	$175
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$175
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth per quadrant	No Copay
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant	No Copay
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth per quadrant	No Copay
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces, per quadrant	No Copay
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$175
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$175
D7471	Removal of lateral exostosis (maxilla or mandible)	$175
D7472	Removal of torus palatinus	$175
D7473	Removal of torus mandibularis	$175
D7510	Incision and drainage of abscess – intraoral soft tissue	No Copay
D7520	Incision and drainage of abscess – extraoral soft tissue	No Copay
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	No Copay
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	No Copay
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	No Copay
D7560	Upper sinusotomy for removal of tooth fragment or foreign body	$175
D7670	Alveolus – closed reduction, may include stabilization of teeth	No Copay
D7910	Suture of recent small wound up to 5 cm	No Copay

CDT Code	Procedure	Copay
D7911	Complicated suture – up to 5 cm	No Copay
D7912	Complicated suture – greater than 5 cm	$200
D7953	Bone replacement graft for ridge preservation – per site	$175
D7961	Buccal/labial frenectomy (frenulectomy)	$175
D7963	Frenuloplasty	$175
D7970	Excision of hyperplastic tissue per arch	$175
D7971	Excision of pericoronal flap	$175
13.26 Anesthesia		
D9222	Deep sedation/General anesthesia – 1st 15 minutes	$250*
D9223	Deep sedation/General anesthesia – each additional 15 minutes	No Copay*
D9230	Inhalation of nitrous oxide analgesia, anxiolysis (per visit)	$40
D9239	IV conscious sedation/analgesia – 1st 15 minutes	$125*
D9243	IV conscious sedation/analgesia – each additional 15 minutes	No Copay*
D9248	Non-intravenous conscious sedation	$50
	*Must be authorized by the network dentist. See Section 7 (Exclusions).	
13.27 Miscellaneous		
D9110	Palliative (emergency) treatment of dental pain – per visit	No Copay
D9120	Fixed partial denture sectioning	No Copay
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	No Copay
D9420	Hospital or ambulatory surgical center call (dental treatment provided in a hospital setting; facility fees not covered; other applicable service copays still apply)	$100
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	No Copay
D9440	Emergency treatment – after office hours	$25
D9910	Application of desensitizing medicament	No Copay
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	No Copay
D9920	Behavior management	No Copay
D9930	Treatment of post-surgical complications – unusual circumstance, by report	No Copay
D9951	Occlusal adjustment- limited	No Copay
D9952	Occlusal adjustment – complete	No Copay
D9970	Enamel microabrasion	No Copay
	Out-of-area emergency reimbursement (You will be reimbursed up to $100 for covered services)	Charges over $100
13.28 Orthodontia		
	Comprehensive orthodontia treatment – cleft palate with or without cleft lip	$450
	All other comprehensive orthodontia treatment	$2,200
D8660	Pre orthodontic treatment services	
	Initial orthodontic exam	$25

CDT Code	Procedure	Copay
	Study models and x-rays	$125
	Case presentation	No Copay
13.29 Dental Implants		
	Dental Implant Surgery. The following dental implant services are covered at 100%, **up to an annual dental implant benefit maximum of $1,500**. The annual dental implant benefit maximum is the maximum dollar amount covered for the below dental implant services in a calendar year.	
D6010	Surgical placement of implant body: endosteal implant	
D6011	Second stage implant surgery	
13.30 Exclusions		
	See Section 7.	

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2365 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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

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

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

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

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

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DELTA DENTAL®

Delta Dental of Oregon & Alaska

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

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ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

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PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

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ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

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ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - (1-877-605-3229 (TTY: 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങൾ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

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AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.

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