



Oregon Group Dental Plan

City of Albany

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Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon

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SECTION 1. WELCOME

Oregon Dental Service (ODS), doing business as Delta Dental Plan of Oregon (abbreviated as Delta Dental), is pleased to have been chosen by the Group as its dental plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

This dental plan is offered by Delta Dental with dental care services provided by Willamette Dental Group, P.C. Members may direct questions to one of the numbers listed in Section 2 or access tools and resources on Delta Dental's personalized member website, myModa, at www.modahealth.com. myModa is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

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

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

SECTION 2. CONTACT INFORMATION

Delta Dental Website (log in to **myModa**)
www.modahealth.com

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

Telecommunications Relay Service for the hearing impaired
711

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

Willamette Dental Group Website
www.willamettedental.com

Making Appointments with a Network Dentist
Toll-free 855-433-6825, Option 1

Selecting a Network Dentist
Toll-free 855-433-6825, Option 1

Eligibility Inquiries
Toll-free 888-217-2365
En Español 877-299-9063

Appeals
Toll-free 855-433-6825, Option 3

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

2.1 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 11 and Section 13.

SECTION 3. USING THE PLAN

This dental plan is easy to use. All of the paperwork takes place at the dentist's office, and members do not submit claims for reimbursement (except for out of area dental emergencies). Benefits are provided for services rendered by dentists selected from the network named below. Services must be performed by a network dentist unless members are referred to an outside dentist or specialist by a network dentist. The amount members pay for a covered service is listed in Section 15.

A member may choose any general dentist from the Willamette Dental Directory, which is available by visiting the Willamette Dental Group website or by calling the "Selecting a Dentist" phone number listed in Section 2 for assistance.

Members should make an appointment in advance with a network dentist to access dental care. Members must pay for the member copayments at the time of dental service. If necessary, a network dentist will refer a member to an outside dentist or specialist. **Dental services that are performed by an outside dentist or dental care provider will not be covered by the Plan, unless referred by a network dentist or for an out of area dental emergency.**

For questions about the Plan, members should contact Customer Service.

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

SECTION 4. BENEFITS AND LIMITATIONS

The Plan covers services when performed by a network provider. Details on specific services covered are available in Section 15. Some procedures require a copayment, and members must pay this amount directly to the network dentist. If a member obtains dental services from an outside dentist or dental care provider, no benefits are payable and he or she will be responsible for the expenses incurred. (See sections 4.5 and 4.7 for exceptions.)

Before visiting a network provider, members should call the network and make an appointment. Members who need to change a scheduled appointment should call in advance for cancellation and re-schedule for another day. There is a missed appointment fee if the appointment is canceled with less than 24-hour notice.

4.1 MEMBER COPAYMENT SCHEDULE

Details on covered services and copayments can be found in Section 15.

4.2 BENEFITS AND LIMITATIONS

4.2.1 Teeth Cleaning

Teeth cleaning frequency is determined at a member's visit with a network dentist, who will make this determination based on what is dentally necessary. Frequency of other services is also determined by the network dentist.

4.2.2 Endodontic Retreatment

When initial root canal therapy was performed by a network dentist, retreatment will be covered as part of the initial treatment for the first 24 months. After that time, standard cost sharing applies.

4.3 EXTENSION OF BENEFITS

Dental benefits will be extended to cover the following services and supplies if coverage ends for any reason other than nonpayment of premium or termination of the member's services through the network.

4.3.1 Crowns and Bridges

When the final impressions are taken prior to termination, seating of the crown or bridge is covered up to 60 days after termination and adjustments will be covered up to 6 months after seating.

4.3.2 Removable Prosthetic Devices

When final impressions are taken prior to termination, delivery of the prosthesis is covered up to 60 days after termination and adjustments will be covered up to 6 months after seating. Laboratory relines will not be covered after termination.

4.3.3 Immediate Dentures

When final impressions are taken prior to termination, the delivery of dentures will be covered up to 60 days after termination. However, if coverage for a member terminates prior to the actual extraction of teeth, the extractions will not be covered.

4.3.4 Root Canal Therapy and Root Canal Retreatment

When the root canal is started prior to termination, completion of treatment is covered up to 60 days after termination. A pulpotomy is considered definitive treatment and is not considered a root canal start. If the root canal fails after 60 days from the date of treatment and coverage has terminated, retreatment will not be covered. Restorative work is a separate procedure and is not covered after termination.

4.3.5 Extractions

Post-operative visit for extractions performed prior to termination will be covered for 60 days from the date of the extraction. Extractions are considered a separate procedure from prosthetic procedures. If a member has teeth extracted in preparation for a prosthetic device, but coverage terminates prior to the final impressions, the prosthetic device will not be covered.

4.4 HOSPITAL AND OTHER FACILITY CARE

Services may be provided in a hospital only when:

- a. A hospital setting is dentally necessary
- b. The services are authorized, in writing, in advance by the network

Hospital facility charges are not a covered benefit.

4.5 REFERRED DENTAL CARE

If a network dentist refers a member to an outside specialist to obtain services that are covered under the Plan, the member is only responsible to pay the member copayments as shown in Section 15 and any applicable service charges.

However, the Plan does not cover treatment that is not authorized by a network dentist. Members are responsible for any additional charges by the outside dentist or specialist for procedures other than those specifically authorized by a network dentist.

4.6 EMERGENCIES

If there is an emergency, members should call their network provider to schedule an emergency appointment. Members are responsible for the applicable office visit copayment as shown in Section 15 if emergency services are received within network office hours. For after hour emergencies, members are subject to a separate after hours copayment in addition to the applicable emergency office visit copayment.

Most network offices are open 7:00 a.m. to 6:00 p.m., Monday through Friday and select Saturdays.

4.7 OUT OF AREA EMERGENCIES

Members who are not able to get to a network provider while traveling at least 50 miles from a network office may go to any licensed dentist to obtain treatment. The maximum amount of reimbursement is \$100 per visit less any applicable copayments. Claims for out of area emergency treatment by an outside dentist must be paid in full by the member and then be sent to the network for reimbursement (see Section 10.1).

For after-hours emergencies, members are also subject to a separate after hour emergency care copayment.

SECTION 5. ORTHODONTIC BENEFIT

5.1 ORTHODONTIC BENEFITS

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

There is no deductible or lifetime maximum benefit amount. The Plan will pay 100% after the applicable cost sharing. The pre-orthodontic service copayment will be credited toward the overall orthodontic copayment.

Copayments may be adjusted based upon the services necessary to complete the treatment if orthodontic treatment is started prior to the effective date of coverage.

5.2 LIMITATIONS

Orthodontic treatment that began before a member is covered under the Plan may be pro-rated according to the extent of orthodontic services required to complete the treatment.

If coverage terminates prior to completion of orthodontic treatment, there may be additional charges for orthodontic services rendered if treatment continues after the termination of coverage.

The General Office Visit Copayment listed in Section 15 is charged at each visit for orthodontic treatment. Other services provided in connection with orthodontic treatment (e.g., extraction or frenectomy) are subject to the copayments listed in Section 15.2 through 15.12, and are 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, if all of the following requirements are met:

- a. A network dentist determines that dental implants are dentally appropriate for the member.
- b. A network dentist prepares the treatment plan for dental implants prior to initiating any implant treatment.
- c. All dental implant services are provided by a network dentist or under a referral from a network dentist.
- d. The member follows the treatment plan prescribed by the network dentist.
- e. The member makes payment of amounts due.
- f. The dental implant service is listed as covered in this Plan and is not otherwise limited or excluded.

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 this plan will cover for benefits for the below dental implant services in a calendar year.

CDT Code and Procedure Description
D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery

If the member's coverage ends before the completion of the dental implant services, the cost of any remaining treatment is the member's responsibility.

6.2 LIMITATIONS

The benefit for dental implants is subject to the following limitations:

- a. Benefits for surgical placement of a dental implant are limited to 1 implant per calendar year.
- b. Dental implants to replace an existing bridge or existing denture are not covered, unless 5 years have elapsed since the placement of the bridge or delivery of the denture.

6.3 EXCLUSIONS

The following services are not covered under this benefit for dental implants:

- a. Any dental implant services and related services that are not listed as covered on this plan.
- b. Bone grafting.
- c. Cone beam CT X-rays and tomographic surveys.
- d. Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).

- e. A dental implant surgically placed prior to the member's effective date of coverage under this plan that has not received final restoration.
- f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- g. Maintenance, repair, replacement, or completion of an existing implant started or placed by an outside dentist of specialist without a referral from a network dentist.
- h. Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the effective date of coverage under this plan.
- i. Treatment of a primary or transitional dentition.

SECTION 7. EXCLUSIONS

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

Accidental Injury

Services that are provided for accidental injury to natural teeth more than 12 months after the date of the accident

Anesthesia or Sedation

Unless otherwise covered in Section 15

Athletic Activities

Including any injuries sustained while practicing for or competing in a professional or semiprofessional athletic contest. Semiprofessional athletics means an athletic activity for gain or pay that requires an unusually high level of skill and substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.

Benefits Not Stated

Services or supplies not specifically described in this handbook as covered services

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

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

Cosmetic Services

Including bleaching

Experimental or Investigational Procedures

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

Facility Fees

Including additional fees charged by the dentist for hospital, extended care facility or home care treatment (see section 4.4 for exceptions)

Federal, State or Governmental Program

Coverage provided by any federal, state or governmental program, except where required by law (e.g., cases of emergency or for coverage provided by Medicaid)

Full-Mouth Reconstruction

Habit-Breaking or Stress-Breaking Appliances

Illegal Acts, Riot or Rebellion, War

Services and supplies for treatment of an injury or condition caused by or arising out of a member's voluntary participation in a riot or arising directly from an illegal act. This includes any expense caused by, arising out of, or related to war, whether or not declared, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force, or usurped power, by any government, military or other authority

Inmates

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

Intentionally Self-Inflicted Injuries

The fact that a member may be under the influence of any chemical substance shall not be considered a limitation on the ability to form the intent specified in this exclusion.

Materials Not Approved by the American Dental Association**Medications and Supplies**

Unless otherwise covered in Section 15

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 arising out of self-employment

OSHA Requirements

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

Orthognathic Surgery**Precision Attachments and Other Special Techniques****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 and replacement of dental appliances that are damaged due to abuse, misuse or neglect are not covered. Replacement of an existing denture, crown, inlay, onlay or other prosthetic appliance is covered if the appliance is more than five years old and replacement is dentally necessary. Exceptions to replacement limitations may be made for a member under age 19 in the case of acute trauma or catastrophic illness affecting the oral condition and resulting in additional tooth loss.

Restorations on Posterior Teeth

Veneers on posterior teeth

Self Treatment

Services provided by a member to herself or himself

Services Not Provided by a Dental Provider

Charges by any person other than a licensed dentist, licensed denturist or licensed hygienist

Service Related Conditions

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

Services Otherwise Available

Charges that would not have been made, or that members would have had no obligation to pay in the absence of coverage under the Plan.

Taxes**Third Party Liability Claims**

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

TMJ

Treatment of any disturbance of the temporomandibular joint (TMJ)

Treatment Before Coverage Begins**Treatment Not Dentally Necessary**

Including services:

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

Treatment with Multiple Visits

If started or ordered before coverage effective date or installed or delivered more than 60 days after coverage has ended.

Tumor Related Services

Unless otherwise covered in Section 15

SECTION 8. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 9.6).

8.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

- a. Is a permanent documented full time employee, sole proprietor, owner, business partner, or corporate officer of the Group
- b. Is not a leased, seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor
- c. Is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
- d. Regularly works the required hours per week as specified by City of Albany and;
- e. Satisfies any orientation and/or eligibility waiting period

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws.

8.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (see addendum) is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are also subject to the Plan's child age limit.

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

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

A subscriber's child who has sustained a disability making him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Delta Dental will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

- a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
- b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)

- c. Relevant recent hospitalization records (e.g., history and physical, discharge summary) if applicable
- d. Disability information from prior carrier

Delta Dental will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Delta Dental will be required on an ongoing basis except in cases where the disability is certified to be permanent.

8.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that the applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

8.4 NEW DEPENDENTS

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

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

If a subscriber files an Affidavit of Domestic Partnership with the Group, the domestic partner and his or her children are eligible for coverage.

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

8.5 ELIGIBILITY AUDIT

Delta Dental reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee timecards, member birth certificates, adoption paperwork, marriage certificates, domestic partnership registration and any other evidence necessary to document eligibility on the Plan.

SECTION 9. ENROLLMENT

9.1 ENROLLING ELIGIBLE EMPLOYEES

A complete and signed application for the eligible employee and any dependents to be enrolled must be filed with the Group within 31 days of becoming eligible to apply for coverage.

The subscriber must notify the Group and Delta Dental of any change of address.

9.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, domestic partnership documentation, or adoption or placement for adoption paperwork must be submitted within 31 days of eligibility. The subscriber must notify Delta Dental if family members are added or dropped from coverage, even if it does not affect premiums.

9.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 31 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless:

- a. The person qualifies for special enrollment as described in section 9.4
- b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's insurance plan and request for enrollment is made within 30 days after the court order is issued

Open enrollment occurs once a year at renewal.

9.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights described in sections 9.4.1 and 9.4.2 apply:

- a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
- b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy
- c. To both an eligible employee and his or her dependent if neither is enrolled under 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 coverage is declined when initially eligible or at an open enrollment period because of other dental coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

- a. He or she was covered under a group dental plan or had dental coverage at the time coverage was previously offered
- b. He or she stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined
- c. He or she requests such enrollment not later than 31 days after the previous coverage ended (except for event iv. below, which allows up to 60 days)
- d. One of the following events has occurred:
 - i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
 - ii. His or her prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
 - A. legal separation or divorce
 - B. loss of dependent status per plan terms
 - C. death
 - D. end of employment or reduction in the number of hours of employment
 - E. reaching the lifetime maximum on all benefits
 - F. the plan stops offering coverage to a group of similarly situated persons
 - G. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
 - H. termination of the benefit package option, and no substitute option is offered
 - iii. The employer contributions toward his or her other active (not COBRA) coverage end. If employer contributions stop, the eligible employee or dependent does not have to end coverage to be eligible for special enrollment on a new plan.
 - iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility. Special enrollment must be requested within 60 days of the end of coverage.

9.4.2 Eligibility for Premium Subsidy

If an eligible employee or dependent covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, he or she may enroll in the Plan outside of the open enrollment period.

9.4.3 New Dependents

An eligible employee and spouse or domestic partner and children will also have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, domestic partnership, birth, adoption, or placement for adoption).

9.5 INSURANCE WAIVER

A subscriber may opt-out of this dental coverage if he or she has the ability to enroll in a group sponsored H.S.A. plan through the spouse.

9.6 WHEN COVERAGE BEGINS

Coverage for subscribers begins on the enrollment date or after a waiting period, as specified in the policy.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group begins on the date of marriage or partnership if the marriage, registration or filing date is the first day of the month. Otherwise, coverage begins the first day of the month following the date of marriage, registration or filing.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

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

9.7 WHEN COVERAGE ENDS

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

9.7.1 Termination of the Group Plan

Coverage ends for the Group and members on the date the Plan ends.

9.7.2 Termination by Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, only if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

9.7.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage if the requirements for continuation of coverage are met (see Section 12). The Group must notify Delta Dental of any continuation of coverage and appropriate premiums must be paid along with the Group's regular monthly payment.

9.7.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see Section 12).

If a subscriber

- a. is laid off by the Group; or
- b. experiences a reduction in hours that causes loss of coverage

And within 6 months the subscriber

- a. returns to active work; or
- b. has an increase in hours to qualify for benefits

The subscriber and any eligible dependents may enroll in the Plan on the date of rehire or the date the subscriber works enough hours to qualify for benefits and coverage will begin on that date. The Group must notify Delta Dental that the subscriber has been rehired following a layoff or that the subscriber's hours have been increased, and the necessary premiums for coverage must be paid. Any waiting period required by the Plan will not have to be re-served. All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage.

9.7.5 Termination by the Network

Coverage may terminate if the network has documented good cause for termination, such as an inability to establish or maintain a patient/provider relationship between a member and a network dentist at locations reasonably accessible to the member. Coverage will end on the last day of the month following a 30-day written notice from Delta Dental.

9.7.6 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 on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that a partnership no longer meets the requirements of the Affidavit of Domestic Partnership.
- b. Coverage ends for an enrolled child on the last day of the month in which he or she turns age 26, or that a legal guardianship ends.

The subscriber must notify Delta Dental 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.

9.7.7 Rescission

Delta Dental may rescind a member's coverage back to the effective date, or deny claims at any time for fraud or intentional material misrepresentation by the member or the Group. This may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment and falsification or alteration of claims. Delta Dental reserves the right to retain premium paid as liquidated damages, and the Group and/or member shall be responsible for the full balance of any benefits paid. Delta Dental will notify a member of a rescission 30 days before cancellation of coverage. Should Delta Dental terminate coverage under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of our affiliates.

9.7.8 Continuing Coverage

Information is in Continuation of Dental Coverage (Section 12).

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION AND PAYMENT OF CLAIMS

When a member sees a network dentist, all of the paperwork takes place at the dentist's office and there is no need to submit claims.

Claims for out of area emergency treatment by an outside dentist must be paid in full by the member and then be sent to the following address for reimbursement.

Willamette Dental Group
Attention: Administrative Application Specialist
6950 NE Campus Way
Hillsboro, OR 97124

If a claim form is submitted, it must be completely filled out and signed by the member and the outside dentist. An itemized statement from the outside dentist must also be included. The network has the right to request additional information from the outside dentist needed to process the claim. No reimbursement will be provided unless the requested information is received. All claims must be submitted within 6 months of the date of service. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

10.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to the Member Services Department.

A member with questions or concerns regarding a decision, action, or statement by a network dentist should discuss with the network dentist at the time of the appointment. If the member remains dissatisfied after the discussion, he or she may submit a first level appeal to the network's Member Services Department.

10.2.1 Time Limit for Submitting Appeals

Members have **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

10.2.2 The Appeal Process

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

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

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

10.2.3 First Level Appeals

An appeal must be submitted in writing to the following address: Willamette Dental Group, 6950 NE Campus Way, Hillsboro, OR, 97124. If necessary, the Member Services Department can help with filing an appeal. Written comments, documents, records, and other information relating to the appeal may be submitted. Appeals are investigated by persons who were not involved in the original decision.

The investigation of an appeal of an adverse benefit determination will be completed within 30 days of receipt of the appeal.

10.2.4 Second Level Appeals

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. A second level appeal must be submitted in writing within 60 days of the date of the action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

10.2.5 Additional Member Rights

Members are entitled to additional rights if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should check with the Group to determine if this section is applicable.

These first and second levels of review must be done before a member files a lawsuit in court under ERISA Section 502(a). The right to file suit in court may be lost if the member has not used all of his or her internal appeal rights, which is generally required before filing a lawsuit.

10.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.3.1 Coordination of Benefits (COB)

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

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

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

The first of the following rules that applies will govern:

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

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

- b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)
- c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
 - i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
 - ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
 - iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
 - A. Custodial parent
 - B. Spouse or domestic partner of the custodial parent
 - C. Non-custodial parent
 - D. Spouse or domestic partner of the non-custodial parent
- d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.
- e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plans began on the same day, the birthday rule will apply.
- f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
- g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
- h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

- i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

10.3.1.2 How COB Works

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

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

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

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

10.3.1.3 Effect on the Benefits of This Plan

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

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

10.3.1.4 Definitions

For purposes of this section, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

Complying plan is a plan that follows these COB rules.

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

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

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

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

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

negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

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

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

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

10.3.2 Third Party Liability

A member may have a legal right to recover benefit or dental care costs from a third party as a result of an injury for which benefits were provided by a network provider

The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member, the network will provide benefits to a member based on the understanding and agreement the network is entitled to be reimbursed to the extent allowed under Oregon law for any benefits that it provides that are associated with any injury and are or may be recoverable from a third party, as defined below.

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

10.3.2.1 Definitions

For purposes of section 10.3.2, the following definitions apply:

Benefits means those covered services available under the terms of the Plan and provided by the network, or submitted to the network for payment to or on behalf of a member.

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

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

10.3.2.2 Subrogation

Upon provision of services by the network, the network has, to the extent consistent with Oregon law, the right to pursue the third party in its own name, or in the name of the member. The member shall do whatever is necessary to secure such rights and do nothing to prejudice them. The network is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

10.3.2.3 Right of Recovery

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

- a. The member holds any rights of recovery against the third party in trust for the network, but only for the amount of benefits provided for that injury to the extent the amount is consistent with Oregon law.
- b. The network is entitled to receive the value of benefits, consistent with Oregon law, it has provided for an injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the network is entitled to receive the value of benefits it has paid whether the dental care expenses are itemized or expressly excluded in the third party recovery.
- c. If the network requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the network a proportionate share of reasonable attorney fees as an expense for collecting from the other party.
- d. This right of recovery includes the amount of the benefits provided by the network, out of any recovery made by the member from the third party that is allowed by Oregon law, including, without limitation, any and all amounts paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or dental expenses of the member), regardless of the characterization of the recovery or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The network's recovery rights will not be reduced due to the member's own negligence.
- e. If it is reasonable to expect that the member will incur future expenses for which benefits might be provided by the network, the member shall seek recovery of such future expenses in any third party claim.
- f. In third party claims involving the use or operation of a motor vehicle, the network, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon or under applicable state law.

10.3.2.4 Additional Provisions

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

- a. The member shall cooperate with the network to protect its recovery rights, including by:
 - i. Signing and delivering any documents the network reasonably requires to protect its rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
 - ii. Providing any information to the network relevant to the application of the provisions of section 10.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
 - iii. Notifying the network of the potential third party claim for which the network may provide benefits
 - iv. Taking such actions as the network may reasonably request to assist it in enforcing its third party recovery rights
- b. The member and his or her representatives are obligated to notify the network in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits provided by the network from the third party
- c. By accepting benefits from the network, the member agrees that it has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.
- d. The member agrees that the network may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 10.3.2.
- e. Even without the member's written authorization, the network may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.3.2.
- f. Section 10.3.2 applies to any member for whom benefits are provided whether or not the event giving rise to the member's injuries occurred before the member became covered under the Plan.
- g. Coordination of benefits (where the member has dental coverage under more than one plan or health insurance policy) is not considered a third party claim.

SECTION 11. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental.

11.4 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.

11.5 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.

11.6 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.

11.7 LIMITATION OF LIABILITY

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

11.8 PROVIDER REIMBURSEMENTS

Network dentists agree that they will accept fees in the amount established by the network as full payment for their services, except for the member's copayment responsibility and service charges and/or non-covered benefit fees as provided for in the Plan. Network dentists agree that their charges to members for covered services will not exceed the copayment amounts listed in Section 15.

11.9 INDEPENDENT CONTRACTOR DISCLAIMER

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

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

11.11 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.

11.12 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.

11.13 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.

11.14 TIME LIMITS 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 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

SECTION 12. CONTINUATION OF DENTAL COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Group to find out if they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

12.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

12.1.1 Introduction

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

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

Note: In section 12.1 the term “domestic partner” refers only to a registered domestic partner, as defined in Section 14.

12.1.2 Eligibility

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

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

12.1.3 Notice and Election Requirements

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

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

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

its designated third party administrator does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

12.1.4 Premiums

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

12.1.5 When Coverage Ends

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

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

12.2 COBRA CONTINUATION COVERAGE

12.2.1 Introduction

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

- a. Delta Dental will offer no greater COBRA rights than the COBRA statute requires
- b. Delta Dental will not provide COBRA coverage for members who do not comply with the requirements outlined below
- c. Delta Dental will not provide COBRA coverage if the COBRA Administrator does not provide the required COBRA notices within the statutory time periods or if the COBRA Administrator otherwise does not comply with any of the requirements outlined below
- d. Delta Dental will not provide a disability extension if the COBRA Administrator does not notify Delta Dental within 60 days of its receipt of a disability extension notice from a member

For purposes of section 12.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

12.2.2 Qualifying Events

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

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

- a. Death of the subscriber
- b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
- c. Divorce or legal separation from the subscriber
- d. The subscriber becomes entitled to Medicare

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

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

- a. Death of the subscriber
- b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
- c. Parents' divorce or legal separation
- d. Subscriber becomes entitled to Medicare
- e. Child ceases to be a child under the Plan

Domestic Partners. A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member under COBRA and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ends immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Retirees. If the subscriber's former employer files a chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

12.2.3 Continuation Upon Retirement

Retired employees (retirees) and their dependents are eligible to continue coverage subject to the following:

- a. The retiree must apply for continued coverage within 60 days after retirement.
- b. The retiree must have been continuously covered under the Plan for at least twenty-four (24) months.
- c. The retiree must be receiving benefits for PERS (Public Employee Retirement System) or from a similar retirement plan offered by the Group.

The retiree must enroll in the same benefit plan option they had as an active employee and may not transfer to another plan option offered by the Group. If the Group changes plan benefits, the retiree's plan benefits will change accordingly.

Except for newly acquired dependents due to marriage, registration of domestic partnership, birth, or adoption, only the retiree's dependents who were covered at the time of retirement may continue coverage under this provision. The retiree may add a new spouse, domestic partner, or other newly acquired dependent after retirement if family coverage is available. When a premium increase is required, a completed enrollment application must be submitted within 31 days of the date of marriage, registration of the domestic partnership, birth, or adoption.

Coverage under this provision will end for the subscriber according to the following:

- a. When the full premium is not paid or when the coverage is voluntarily terminated, the retiree's coverage will end on the last day of the month for which premium was paid.
- b. When the retiree becomes eligible for federal Medicare coverage, his or her coverage will end on the last day of the month preceding Medicare eligibility.
- c. When the Group's policy is terminated, the retiree's coverage will end on the date of termination.

Coverage under this provision will end for dependents according to the following:

- a. When the full premium for the dependent is not paid or when the dependent's coverage is voluntarily terminated by the retiree or the dependent, coverage will end on the last day of the month for which premium was paid.
- b. When the retiree's dependent becomes eligible for federal Medicare coverage, coverage will end on the last day of the month preceding Medicare eligibility.
- c. When the retiree dies, divorces, or dissolves a domestic partnership, the dependent's coverage will end on the last day of the month following the death, divorce, or dissolution of the domestic partnership.
- d. When the dependent child is no longer considered a dependent under the Plan, the dependent's coverage will end on the last day of the month of their eligibility.
- e. When the Group's policy is terminated, the dependent's coverage will end on the date of the termination.

12.2.4 Other Coverage

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

12.2.5 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage ends as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

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

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

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

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

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

12.2.6 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premium. Delta Dental will not send a bill for any payments due. The member is responsible for paying the applicable premium when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

12.2.7 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. When coverage is lost due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members other than the subscriber who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death. Coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

12.2.8 Extending the Length of COBRA Coverage

An extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

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

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

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

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premiums.

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

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

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 12.1).

12.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 8.4 and 9.2), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

- a. Any required premiums are not paid in full on time
- b. A member becomes covered under another group dental plan
- c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
- d. The Group ceases to provide any group dental plan for its employees
- e. During a disability extension period (section 12.2.8), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be informed of any address changes.

12.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will end if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber asks to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

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

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

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

12.4 FAMILY AND MEDICAL LEAVE

Subscribers should check with the Group to find out if they qualify for this coverage. If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

- a. Affected members will remain eligible for coverage during a family and medical leave.
- b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.
- c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

12.5 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union or trust must continue to pay Delta Dental the premiums 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. A subscriber accepts full-time employment with another employer
- c. A subscriber otherwise loses eligibility under the Plan

SECTION 13. 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). Members should ask the Group if this section is applicable.

13.1 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.

13.2 INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Group's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Group may make a reasonable charge for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Group is required by law to furnish each subscriber with a copy of this summary annual report.

13.3 CONTINUATION OF GROUP DENTAL PLAN COVERAGE

Subscribers are entitled to continue dental care coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

13.4 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 him or her from obtaining a benefit or exercising rights under ERISA.

13.5 ENFORCEMENT OF RIGHTS

If a claim for benefits is denied or no action is taken, in whole or in part, members 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 members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report is requested from the Group and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 10.2). In addition, a member who disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if a member is discriminated against for asserting his or her rights, the member 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 the member is successful, the court may order the person who has been sued to pay these costs and fees. If the member loses, the court may order him or her to pay these costs and fees, (e.g., if it finds the claim is frivolous).

13.6 ASSISTANCE WITH QUESTIONS

For questions about this section or a member's rights under ERISA, or for assistance in obtaining documents from the Group, members should contact one of the following:

Employee Benefits Security Administration
Seattle District Office
300 Fifth Avenue, Suite 1110
Seattle, Washington 98104
206-757-6781

Office of Outreach, Education and Assistance
US Department of Labor
200 Constitution Avenue N.W.
Washington D.C., 20210
866-444-3272

Information and assistance is also available through their website: dol.gov/agencies/ebsa
Members may also obtain publications about their rights and responsibilities under ERISA by calling the Office of Outreach, Education and Assistance.

SECTION 14. DEFINITIONS

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

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

Benefits means those 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 means a period beginning January 1st and ending December 31st.

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

Copay and Copayment means the fixed dollar amount listed in the member copayment schedule (see Section 15) to be paid by a member. Other than service charges, this is the only amount members must pay a network dentist for a covered service.

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

Dentally Necessary means services that:

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

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

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

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

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

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner

- a **Registered Domestic Partner** means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government
- b **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group's affidavit of domestic partnership for a minimum of 6 months

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

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

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

Investigational Service or Supply means a service or supply (including but not limited to equipment, drugs, devices, and other items) that is determined by the network to meet any one of the following:

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

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

Network is the exclusive provider group that provides dental care to members.

Network Dentist means a licensed dentist who is employed by or is under contract with the network or any of its affiliates to provide dental services.

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

Outside Dentist or Specialist means a licensed dentist who is not employed by or under contract with the network.

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

The **Plan** is the dental benefit plan sponsored 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 of all teeth.

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

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

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

Service Charge means a charge for a late cancellation of an appointment, for failing to keep or cancel an appointment and/or a delinquent account charge.

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

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

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

SECTION 15. SCHEDULE OF COVERED SERVICES AND COPAYMENTS

The Member is responsible for payment of the General Office Visit Charge Copayment or the Specialist Office Visit Charge Copayment at each visit. In addition to the office visit charge copayment, a separate, additional copayment applies to some covered services as shown below. Copayments are due at the time of service.

CDT Code	Procedure	Copayment
15.1 General Office Visit Charge		\$5
Specialist Office Visit Charge		\$30
15.2 Diagnostic and Preventive Services		
D0120	Periodic oral evaluation -	No Copay
D0140	Limited oral evaluation – problem focused	No Copay
D0145	Oral Evaluation – patient under 3 years	No Copay
D0150	Comprehensive oral evaluation	No Copay
D0160	Detailed and extensive oral evaluation – problem focused	No Copay
D0170	Re-evaluation – limited	No Copay
D0180	Comprehensive periodontal evaluation	No Copay
D0210	Intraoral – complete series x-rays	No Copay
D0220	Periapical – first film	No Copay
D0230	Periapical – each additional film	No Copay
D0240	Intraoral – occlusal film	No Copay
D0250	Extraoral – first film	No Copay
D0260	Extraoral – each additional film	No Copay
D0270	Bitewing – single film	No Copay
D0272	Bitewings – 2 films	No Copay
D0273	Bitewings – 3 films	No Copay
D0274	Bitewings – 4 films	No Copay
D0277	Vertical bitewings – 7 to 8 films	No Copay
D0330	Panoramic x-rays	No Copay
D0340	Cephalometric film	No Copay
D0350	Oral/facial images	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 fluoride varnish	No Copay
D1208	Topical application of fluoride	No Copay
D1310	Nutritional counseling	No Copay
D1320	Tobacco counseling	No Copay
D1330	Oral hygiene instructions	No Copay
D1351	Sealant – per tooth	No Copay

15.3 Space Maintainers		
D1510	Space maintainer – fixed – unilateral	No Copay
D1515	Space maintainer – fixed – bilateral	No Copay
D1520	Space maintainer – removable – unilateral	No Copay
D1525	Space maintainer – removable – bilateral	No Copay
D1550	Re-cementation of space maintainer	No Copay
D1555	Removal of fixed space maintainer	No Copay
15.4 Restorative Dentistry		
a. Amalgam Restorations		
D2140	Fillings – 1 surface	No Copay
D2150	Fillings – 2 surfaces	No Copay
D2160	Fillings – 3 surfaces	No Copay
D2161	Fillings – 4 or more surfaces	No Copay
b. Resin-based Composite Restorations		
D2391	Resin-based composite – 1 surface, posterior (primary tooth) (permanent tooth)	No Copay
		Not Covered
D2392	Resin-based composite – 2 surfaces, posterior (primary tooth) (permanent tooth)	No Copay
		Not Covered
D2393	Resin-based composite – 3 surfaces, posterior (primary tooth) (permanent tooth)	No Copay
		Not Covered
D2394	Resin-based composite – 4 or more surfaces, posterior (primary tooth) (permanent tooth)	No Copay
		Not Covered
c. Inlay/Onlay (cast restorations)		
D2510	Inlay – metallic, 1 surface	\$100
D2520	Inlay – metallic, 2 surfaces	\$100
D2530	Inlay – metallic, 3 or more surfaces	\$100
D2542	Onlay – metallic, 2 surfaces	\$100
D2543	Onlay – metallic, 3 surfaces	\$100
D2544	Onlay – metallic, 4 or more surfaces	\$100
D2610	Inlay – porcelain/ceramic – 1 surface	\$100
D2620	Inlay – porcelain/ceramic – 2 surfaces	\$100
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	\$100
D2642	Onlay – porcelain/ceramic – 2 surfaces	\$100
D2643	Onlay – porcelain/ceramic – 3 surfaces	\$100
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	\$100
D2910	Recement inlay, onlay, or partial coverage restoration	No Copay
15.5 Crowns		
D2710	Crown – resin-based composite	\$100
D2740	Crown – porcelain/ceramic	\$100
D2750	Crown – porcelain/noble	\$100
D2782	$\frac{3}{4}$ crown – noble	\$100
D2792	Full cast crown – noble	\$100
D2910	Recement inlay, onlay, or partial coverage restoration	No Copay
D2920	Recement crown	No Copay

D2930	Stainless steel crown – primary	No Copay
D2931	Stainless steel crown – permanent	No Copay
D2932	Crown – prefabricated resin	No Copay
D2933	Crown – prefabricated stainless steel with resin window	No Copay
D2940	Protective restoration	No Copay
D2950	Core buildup, including any pins	No Copay
D2951	Pin retention – per tooth, in addition to restoration	No Copay
D2954	Prefabricated post and core	No Copay
D2955	Post removal	No Copay
D2957	Each additional prefabricated post – same tooth	No Copay
D2975	Coping	No Copay
D2980	Repair crown (due to restorative material failure)	No Copay
15.6 Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	No Copay
D3120	Pulp cap – indirect (excluding final restoration)	No Copay
D3220	Pulpotomy – A pulpotomy is not the first stage of a root canal. A pulpotomy is a separate procedure.	No Copay
D3221	Gross pulpal debridement, primary and permanent teeth	No Copay
D3230	Pulpal therapy – primary anterior	No Copay
D3240	Pulpal therapy – primary posterior	No Copay
D3310	Root canal therapy – anterior	No Copay
D3320	Root canal therapy – bicuspid	No Copay
D3330	Root canal therapy – molar	No Copay
D3331	Treatment of root canal obstruction – non-surgical access	No Copay
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	No Copay
D3333	Internal root repair of perforation defects	No Copay
D3346	Retreatment – anterior	No Copay
D3347	Retreatment – bicuspid	No Copay
D3348	Retreatment – molar	No Copay
D3351	Apexification/recalcification – initial visit	No Copay
D3352	Apexification/recalcification – interim visit	No Copay
D3353	Apexification/recalcification – final visit	No Copay
D3410	Apicoectomy/recalcification – anterior	No Copay
D3421	Apicoectomy/recalcification – bicuspid (1 st root)	No Copay
D3425	Apicoectomy/recalcification – molar (1 st root)	No Copay
D3426	Apicoectomy/recalcification – (each additional root)	No Copay
D3430	Retrograde filling – per root	No Copay
D3450	Root amputation per tooth	No Copay
D3920	Hemisection	No Copay
D3950	Canal prep-preform dowel/post	No Copay
15.7 Periodontics		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	No Copay
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	No Copay
D4240	Gingival flap – 4 or more teeth per quadrant	No Copay
D4241	Gingival flap – 1 to 3 teeth per quadrant	No Copay
D4249	Crown lengthening – hard tissue	No Copay

D4260	Osseous surgery – 4 or more teeth per quadrant	No Copay
D4261	Osseous surgery – 1 to 3 teeth per quadrant	No Copay
D4263	Bone replacement graft – retained natural tooth - 1 st 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	No Copay
D4273	Autogenous connective graft procedure including donor and recipient surgical sites) first tooth	No Copay
D4274	Mesial/distal wedge procedure	No Copay
D4277	Free soft tissue graft procedure, 1st tooth or edentulous tooth position in graft	No Copay
D4278	Free soft tissue graft procedure, each additional tooth or edentulous tooth position in graft	No Copay
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	No Copay
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	No Copay
D4355	Preliminary full-mouth debridement	No Copay
D4381	Antimicrobial irrigation	No Copay
D4910	Periodontic maintenance following therapy	No Copay
15.8 Prosthodontics – Removable		
D5110	Complete (upper denture)	\$200
D5120	Complete (lower denture)	\$200
D5130	Immediate (upper denture)	\$200
D5140	Immediate (lower denture)	\$200
D5211	Upper partial resin base	\$200
D5212	Lower partial resin base	\$200
D5213	Upper partial cast metal frame	\$200
D5214	Lower partial cast metal frame	\$200
D5281	Partial-removable unilateral	\$200
D5410	Adjustment – complete denture, upper	No Copay
D5411	Adjustment – complete denture, lower	No Copay
D5421	Adjustment – partial denture, upper	No Copay
D5422	Adjustment – partial denture, lower	No Copay
D5510	Repair broken denture no teeth damaged	No Copay
D5520	Repair denture replace missing or broken teeth (each tooth)	No Copay
D5610	Repair resin base	No Copay
D5620	Repair cast framework	No Copay
D5630	Repair or replace clasp – per tooth	No Copay
D5640	Replace 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 - upper	No Copay
D5671	Replace all teeth and acrylic on cast metal framework - lower	No Copay
D5710	Rebase complete upper denture	No Copay
D5711	Rebase complete lower denture	No Copay
D5720	Rebase upper partial denture	No Copay

D5721	Rebase lower partial denture	No Copay
D5730	Reline complete upper denture (chairside)	No Copay
D5731	Reline complete lower denture (chairside)	No Copay
D5740	Reline upper partial denture (chairside)	No Copay
D5741	Reline lower partial denture (chairside)	No Copay
D5750	Reline upper denture (lab)	No Copay
D5751	Reline lower denture (lab)	No Copay
D5760	Reline upper partial denture (lab)	No Copay
D5761	Reline lower partial denture (lab)	No Copay
D5810	Interim denture – upper	\$100
D5811	Interim denture – lower	\$100
D5820	Interim partial denture upper	\$100
D5821	Interim partial denture– lower	\$100
D5850	Tissue conditioning – upper	No Copay
D5851	Tissue conditioning – lower	No Copay
D5863	Overdenture – complete upper	\$200
D5865	Overdenture – complete lower	\$200
D5864	Overdenture – partial upper	\$200
D5866	Overdenture – partial lower	\$200
D5986	Fluoride gel custom trays	No Copay
15.9 Prosthodontics – Fixed		
D6210	Pontic – cast high noble metal	\$100
D6240	Pontic; porcelain/high noble metal	\$100
D6241	Pontic – porcelain/base metal	\$100
D6545	Cast metal retainer	\$100
D6720	Retainer crown – resin/metal abutment	\$100
D6750	Retainer crown – porcelain metal abutment	\$100
D6780	Retainer crown – ¾ cast metal abutment	\$100
D6790	Retainer crown – full high noble metal abutment	\$100
D6930	Recement bridge	No Copay
D6980	Bridge repair	No Copay
15.10 Oral Surgery		
D7111	Extraction, coronal remnants – primary tooth	No Copay
D7140	Extraction, erupted tooth	No Copay
D7210	Surgical extraction of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	No Copay
D7220	Removal of impacted tooth – soft tissue	No Copay
D7230	Removal of impacted tooth – partially bony	No Copay
D7240	Removal of impacted tooth – completely bony	No Copay
D7241	Removal of impacted tooth – completely bony, complications	No Copay
D7250	Removal of residual roots (cutting procedure)	No Copay
D7260	Oroantral fistula closure	No Copay
D7270	Tooth re-implantation	No Copay
D7280	Exposure of an unerupted tooth	No Copay
D7283	Ortho bracket to aid eruption (if plan covers orthodontia)	No Copay

D7291	Transseptal fiberotomy	No Copay
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)	No Copay
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	No Copay
D7471	Removal of lateral exostosis (maxilla or mandible)	No Copay
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 – soft tissue	No Copay
D7540	Removal of foreign body – hard tissue	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 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	No Copay
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another	No Copay
D7970	Excision of hyperplastic tissue	No Copay
D7971	Excision of pericoronal gingiva	No Copay
15.11 Anesthesia		
D9223	Deep sedation/General anesthesia-first 15 minutes Each additional 15 minutes	Not Covered Not Covered
D9230	Nitrous oxide (per visit)	\$40
15.12 Miscellaneous		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	No Copay
D9120	Fixed partial denture sectioning	No Copay
D9310	Consultation – per session	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)	\$125
D9430	Observation visit	No Copay
D9440	Emergency treatment – after office hours	\$20
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 (The member will be reimbursed up to \$100 for covered services)	Charges in excess of \$100
	Late cancellation of appointment without 24 hour notice	\$30
	Missed appointment fee	\$30
15.13 Orthodontia		
	Comprehensive orthodontia treatment	\$1,800
D8660	Pre orthodontic treatment services	
	Initial orthodontic exam	\$25
	Study models and x-rays	\$125
	Case presentation	No Copay
15.14 Exclusions		
See Section 7.		

Nondiscrimination notice

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

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

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

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

888-374-8906 (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

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.

Dave Nessler-Cass coordinates our nondiscrimination work:

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

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 60667319 (6/20)



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

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

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

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

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

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

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

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

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

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با (TTY: 711) 1-877-605-3229 تماس بگیرید.

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

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

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

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

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

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

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

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

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

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

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

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

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

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





For help, call us directly at 888-217-2363.
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240