DELTA DENTAL®

# 2024

## Oregon Group Dental Plan

Salem Health Hospitals and Clinics
Delta Dental PPO Plan Preventive First
January 1, 2024
10001832



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

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## SECTION 1. WELCOME TO DELTA DENTAL PLAN OF OREGON

The Plan is self-funded. This means money that pays your claims comes from the Group. We are pleased your Group has chosen Delta Dental to provide claims and other administrative services. Where this book talks about Delta Dental paying claims, it means we are issuing benefits that the Group is providing (paying).

This handbook will give you important information about the Plan's benefits, limitations and procedures. It does not waive any of the conditions of the Plan as set out in the Plan Document. The Plan is self-funded and the Group has contracted with Delta Dental Plan of Oregon to provide claims and other administrative services.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.deltadentalor.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

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

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

# SECTION 2. MEMBER RESOURCES

## 2.1 CONTACT INFORMATION

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

**Dental Customer Service Department**
Toll-free 833-212-5029
En español 877-299-9063

**Telecommunications Relay Service** for the hearing impaired
711

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

## 2.2 MEMBER ID CARD

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

## 2.3 NETWORK

Network Information (section 3.1) explains how networks work. This is the network for your Plan.

**Dental network(s)**
Delta Dental Premier
Delta Dental PPO

## 2.4 OTHER RESOURCES

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

# SECTION 3. USING THE PLAN

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

At a first appointment, tell the dentist that you have dental benefits administered by Delta Dental. You will need to provide your ID number and Delta Dental group number to the dentist. These numbers are on your ID card.

## 3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. This plan offers the same annual maximum plan payment limit, deductibles and coinsurance whether you see an in-network dentist (Delta Dental PPO or Delta Dental Premier) or an out-of-network dentist.

If you choose an in-network dentist (available on your Member Dashboard by using Find Care), all of the paperwork takes place between the dentist's office and us. If you are outside Oregon, Delta Dental Plans Association provides offices and/or contacts in every state. We can process dental claims for services you get any place in the world.

If you need dental care, you may go to any dental office. There are differences in how the Plan pays for in-network Delta Dental PPO dentists, Delta Dental Premier dentists and out-of-network dentists. You may choose to use any dentist, but we cannot guarantee that any particular dentist will be available.

### 3.1.1 In-Network Delta Dental Dentists

When using a Delta Dental PPO dentist or Delta Dental Premier dentist, the dentist may not charge you the difference between the plan allowance and the billed amount for covered services. Payment to a Delta Dental PPO dentist will be the lesser of the PPO fee schedule and the dentist's actual billed fees. Payment to a Delta Dental Premier dentist will be the lesser of the dentist's filed or contracted fee with Delta Dental or fees actually charged.

### 3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist or dental care provider is at the applicable coinsurance and limited to the amount in the PPO Fee Schedule. You may have to pay the difference between the PPO Fee Schedule amount and the billed charge.

## 3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, we provide a predetermination service. Your dentist may send us a predetermination request to get an estimate of what the Plan would pay. We will process the request according to the Plan's current benefits and return it to your dentist. You and your dentist should review the information before beginning treatment.

## SECTION 4. BENEFITS AND LIMITATIONS

**BENEFITS IN THIS SECTION APPLY TO BOTH**
**DENTAL AND DENTAL + ORTHODONTIA PLANS**

The Plan covers the services listed when performed by a dentist or dental care provider (licensed denturist or licensed hygienist). They are only covered when they are determined to be necessary and customary by the standards of generally accepted dental practice to prevent or treat oral disease or accidental injury. Our dental consultants and dental director determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance (MPA). Benefits will never be paid for services that are beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered by your medical plan are not covered on this Plan except when they are related to an accident.

Covered dental services are grouped in 3 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services and are noted below. See Section 7 for exclusions.

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

All annual or per year benefits or cost sharing accrue based on a calendar year (January 1 through December 31). Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

**Deductible:** $25
Per member (not to exceed $75 per family) per year, or portion thereof
Deductible applies to covered Class II and Class III services

**Annual maximum plan payment limit:**
$1,500 per member per year, or portion thereof
All covered services except class I and orthodontia apply to the annual maximum plan payment limit.
You will have to pay any amount over the annual maximum plan payment limit.

## 4.1 CLASS I
## COVERED SERVICES PAID AT 100% OF THE MAXIMUM PLAN ALLOWANCE

### 4.1.1 Diagnostic

**a. Diagnostic Services:**

i. Exams
ii. Consultations for covered dental procedures
iii. Intra-oral x-rays to assist in determining required dental treatment

**b. Diagnostic Limitations:**

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

### 4.1.2 Preventive

**a. Preventive Services:**

i. Prophylaxis (cleanings)
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Interim caries arresting medicament application
v. Sealants
vi. Space maintainers

**b. Preventive Limitations:**

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year.† Additional periodontal maintenance is covered if you have periodontal disease, up to a total of 2 additional periodontal maintenances per year.
ii. Adult prophylaxis is only covered if you are age 12 and over. Child prophylaxis is covered if you are under age 12.
iii. Topical application of fluoride is covered twice per year if you are under age 19. If you are age 19 and over, topical application of fluoride is covered twice per year if you have a recent history of periodontal surgery or a high risk of decay because of medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene is not a medical disease).
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealants are only covered on the unrestored occlusal surfaces of permanent molars. Benefits are limited to one sealant per tooth during any 5-year period.
vi. Space maintainers are covered for one space per quadrant per lifetime if you are under age 14. Space maintainers for primary anterior teeth or missing permanent teeth or if you are age 14 and over are not covered.

†Additional cleaning benefit is available if you have diabetes or are in the third trimester of pregnancy. To be eligible for this additional benefit, you must enroll in the Oral Health, Total Health program (see Section 5).

## 4.2 CLASS II
### COVERED SERVICES PAID AT 80% OF THE MAXIMUM PLAN ALLOWANCE

### 4.2.1 Restorative

**a. Restorative Services:**
- i. Amalgam fillings and composite fillings to treat decay
- ii. Stainless steel crowns

**b. Restorative Limitations:**
- i. Restorations are not covered within 2 months of interim caries arresting medicament application.
- ii. Inlays are considered an optional service. We will pay an alternate benefit of a composite filling.
- iii. Crown buildups are included in the crown restoration cost. A buildup is covered only if necessary for tooth retention.
- iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains.
- v. Replacement of a stainless steel crown by the same dentist within a 2 years of placement is not covered. The replacement is included in the charge for the original crown.
- vi. See section 4.3.1 for additional limitations when teeth are restored with crowns or cast restorations.

### 4.2.2 Oral Surgery

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

**b. Oral Surgery Limitations:**
- i. A separate, additional charge for alveoloplasty done along with removal of teeth is not covered.
- ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
- iii. A separate charge for post-operative care done within 30 days after an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
- iv. Brush biopsy is covered twice per year. Benefits are limited to the sample collection. Pathology (lab) services are not covered.

### 4.2.3 Endodontic

**a. Endodontic Services:**

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

**b. Endodontic Limitations:**

i. A separate charge for cultures is not covered.
ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. A separate charge for pulp capping is not covered. Pulp capping is considered to be included in the fee for the final restoration.
iv. Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not covered. The retreatment is included in the charge for the original care.
v. A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.

### 4.2.4 Periodontic

**a. Periodontic Services:**

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

**b. Periodontic Limitations:**

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
ii. Periodontal maintenance is covered under Class I, Preventive.
iii. A separate charge for post-operative care done within 3 months after periodontal surgery is not covered.
iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
v. Bone replacement grafts are covered once per quadrant in a 3-year period.
vi. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
vii. Full mouth debridement is limited to once in a 2-year period. If you are age 19 or older, it is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2-years.

### 4.2.5 Anesthesia

**a. General anesthesia or IV sedation**

Covered only:

i. In conjunction with covered surgical procedures done in a dental office
ii. When necessary due to concurrent medical conditions

## 4.3 CLASS III
### COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

#### 4.3.1 Restorative

**a. Restorative Services:**

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

**b. Restorative Limitations:**

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See 4.2.1 for limitations on buildups.
ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. We will pay for a gold restoration, and you will have to pay the difference.
iii. If your tooth can be restored by an amalgam or composite filling, but you or your dentist choose another type of restoration, the covered expense is limited to a composite. Crowns are only covered if the tooth cannot be restored by a routine filling.
iv. Restorations are not covered within 2 months of interim caries arresting medicament application.
v. A separate, additional charge to repair a restoration done within 2 years of the original restoration is not covered.
vi. Re-cement or re-bond of a crown, inlay, or veneer by the same dentist is limited to once per lifetime.

#### 4.3.2 Prosthodontic

**a. Prosthodontic Services:**

i. Bridges
ii. Partial and complete dentures
iii. Denture relines
iv. Repair of an existing prosthetic device
v. Implants and implant maintenance
vi. Surgical stent in conjunction with a covered surgical procedure

**b. Prosthodontic Limitations:**

i. A bridge or a full or partial denture is covered once in a 7-year period and only if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last 7 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount is limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only covered to replace missing anterior permanent teeth for age 16 or under when placed within 2 months of the extraction of an anterior tooth. If a specialized or precision device is used, covered expense is limited to the cost of a standard cast partial denture. Cast

restorations for partial denture retainer teeth are not covered unless the tooth requires a cast restoration because it is decayed or broken.

iv. Denture adjustments, repairs and relines*:* A separate, additional charge for denture adjustments, repairs and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.

v. Tissue conditioning is covered no more than twice per denture in a 3-year period.

vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years. The Plan will also cover:
    A. The final crown and implant abutment over a single implant. These benefits are limited to once per tooth or tooth space over the lifetime of the implant
    B. An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device
    C. The final implant-supported bridge retainer and implant abutment, or pontic. This benefit is limited to once per tooth or tooth space over the lifetime of the implant
    D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth
    E. This benefit or alternate benefits is not provided if the tooth, implant or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years

vii. Re-cementing or re-bonding an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.

viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to a corresponding metallic prosthetic. You will have to pay the difference.

ix. Fixed bridges or removable cast partial dentures are not covered if you are under age 16.

### 4.3.3 Other

**a. Other Services:**

i. Athletic mouthguard

ii. Nightguard (occlusal guard)

**b. Other Limitations:**

i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period if you are age 16 and over. These time periods are calculated from the previous date of service. Over the counter athletic mouthguards are not covered.

ii. A nightguard (occlusal guard) is covered once every 5-year period at 100% up to $200 maximum with no deductible. You will have to pay for any amount above the $200 maximum. Repair or reline and adjustment of an occlusal guard is covered once every 12-month period . Over the counter nightguards are not covered.

iii. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

## 4.4 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, we will pay the applicable percentage of the maximum plan allowance for the least costly treatment. You will have to pay the rest of the dentist's fee.

# SECTION 5. ORAL HEALTH, TOTAL HEALTH BENEFITS

Visiting a dentist on a regular basis and keeping your mouth healthy is critical to keeping the rest of your body healthy. Studies have shown a relationship between periodontal disease, bacteria in the mouth and various health problems including pre-term, low birth weight babies and diabetes.

## 5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

The Plan offers a Delta Dental program that provides additional cleanings (prophylaxis or periodontal maintenance) for members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations described in Section 4.

### 5.1.1 Diabetes

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

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

### 5.1.2 Pregnancy

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

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

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. If you are pregnant, you are eligible for a cleaning in the third trimester of pregnancy regardless of when you had a previous cleaning.

## 5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on your Member Dashboard. If you have diabetes, you must include proof of diagnosis if not enrolled in the Salem Health Hospitals and Clinics High Deductible or MHP medical plans.

# SECTION 6. ORTHODONTIC BENEFIT

**THIS BENEFIT IS AVAILABLE WITH THE DENTAL + ORTHODONTIA PLAN ONLY**

Orthodontia, including placement of a device to facilitate eruption of an impacted tooth, is defined as the procedure of treatment for correcting malocclusioned teeth when necessity is established through an in-person clinical examination of the member.

## 6.1 ORTHODONTIC BENEFIT

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

The Plan will pay 50% toward covered orthodontic services, up to the orthodontic lifetime maximum of $1,500.00 per member. This maximum is not included in the annual maximum plan payment limit.

If the Plan has a deductible, it does not apply to orthodontic services.

## 6.2 LIMITATIONS

Pre-orthodontic treatment exam is part of the comprehensive orthodontic treatment plan.

Self-administered orthodontics are not covered.

Payment for orthodontia will end when treatment stops for any reason before completion, or when your eligibility ends or of the Plan ends. If treatment began before you were eligible under the Plan, we will base the Plan's obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

A separate charge for a retainer, or the repair or replacement of an appliance furnished under the Plan is not covered.

## SECTION 7. EXCLUSIONS

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

**Analgesics**
Substances used for pain relief

**Anesthesia or Sedation**
Local anesthetics,
Nitrous oxide
General anesthesia and/or IV sedation except as stated in section 4.2.5

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

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

**Congenital or Developmental Malformations**
Includes treating cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth).

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

**Cosmetic Services**
Any service or supply with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in dental function. Examples include, tooth bleaching and enamel microabrasion

**Duplication and Interpretation of X-rays or Records**

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

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

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

**Hypnosis**

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

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

**Instructions or Training**
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction

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

**Maxillofacial Prosthetics**
Except surgical stents as stated in section 4.3.2

**Medications**

**Missed Appointment Charges**

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

**Orthodontia**
Unless specifically covered by the Plan

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

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

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

**Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth**
Including services only to prevent wear or protect worn or cracked teeth, except occlusal or athletic mouthguards as provided in section 4.3.3. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

**Self-Treatment**
Services you provide to yourself

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

**Services on Tongue, Lip, or Cheek**

**Services Otherwise Available**
Someone else should have been responsible for the cost of these services or supplies. Examples include when payment or compensation should be provided by:

a. Workers' compensation or employer's liability laws
b. Any city, county, state or federal law, except Medicaid
c. Any municipality, county or other political subdivision or community agency without cost to you, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. Separate contracts that are used to provide coordinated coverage and are considered parts of the same plan

**Taxes**

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

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

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

**Translation and Sign Language Services**
Included in the fees for overall patient management and are not covered separately

**Treatment After Coverage Ends**
Except for cast restorations and prosthodontic services that were ordered and fitted while you were still eligible, and then only if they are cemented within 31 days after your eligibility ends. This exception does not apply if the Group transfers its plan to another administrator.

**Treatment Before Coverage Begins**

**Treatment Not Dentally Necessary**
Including services and supplies that are:
a. Not dentally necessary to treat or prevent a dental injury or disease otherwise covered under the Plan
b. Inappropriate with regard to standards of good dental practice
c. Have a poor prognosis

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

**Treatment of Closed Fractures**

# SECTION 8. CLAIMS ADMINISTRATION & PAYMENT

## 8.1 SUBMISSION AND PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim no more than 12 months after the date of service
b. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service.

The date of service is the date you receive the service or supply. You must actually receive the service or supply before we will pay the claim.

Usually, you can show your Delta Dental ID card to the provider, and they will bill us for you. We will pay the provider and send a copy of our payment record to you. The provider will then bill you for any charges that were not covered.

### 8.1.1 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). We may pay claims, deny them or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 8.1.

### 8.1.2 Claim Inquiries

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

### 8.1.3 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

a. If the claim is denied, we will send an EOB explaining the denial
b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it.
c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information.

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 8.1.

## 8.2 APPEALS

Before you file an appeal, call Customer Service (see section 2.1). We may be able to resolve your problem over the phone.

### 8.2.1 Time Limit for Submitting Appeals

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

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

### 8.2.2 The Review Process

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

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

**How First and Second Level Appeals Work**

a. Submit your appeal in writing, on time. If you need help, ask Customer Service
b. Someone who was not involved in the original decision will investigate your appeal
c. We will send the decision to you within 30 days

**Special Circumstances**

The timelines for reviewing your appeal do not apply if:

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

### 8.2.3 Definitions

For purposes of section 8.2, the following definitions apply:

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

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

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

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

## 8.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

### 8.3.1 Coordination of Benefits (COB)

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

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

#### 8.3.1.1 When this Plan Pays First

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

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

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

#### 8.3.1.2 How COB Works

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

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

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

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

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

#### 8.3.1.3 Definitions

For purposes of section 8.3.1, the following definitions apply:

**Plan** is any of the following that provide benefits or services for medical or dental care or treatment:

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

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

If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan does not include:

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

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

These are not allowable expenses:

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

### 8.3.2 Third Party Liability

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

The Plan does not cover benefits when someone else (a third party) is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and agreement that the Plan is entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party.

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

a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for the Plan.

b. The Plan is entitled to be reimbursed for any benefits we pay out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. The Plan is entitled to receive the amount of benefits it has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.

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

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

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

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

If you or your representatives do not comply with the requirements of this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any dental condition related to the third party claim, except for claims related to motor vehicle accidents (see section 8.3.2.1). We may notify dental providers seeking payment that all payments have been suspended and may not be paid.

#### 8.3.2.1 Motor Vehicle Accident Recovery

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

If we require you or your attorney to protect the Plan's recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You will do whatever is required to secure, and may not prejudice, the Plan's rights under this section.

## SECTION 9. ELIGIBILITY & ENROLLMENT

Please see separate booklet furnished by the Group for information regarding eligibility and enrollment or contact the Human Resources Department.

## SECTION 10. CONTINUATION OF DENTAL COVERAGE

Please see separate booklet furnished by the Group for information regarding Continuation of Coverage or contact the Human Resources Department.

## SECTION 11. DEFINITIONS

**Alveoloplasty** is the surgical shaping of the upper or the lower jawbone. It is most commonly done in conjunction with the removal of a tooth or teeth so the gums heal smoothly for the placement of a denture.

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

**Anterior** refers to teeth located at the front of the mouth (tooth chart in Section 13).

**Bicuspid** is a premolar tooth, between the front and back teeth (tooth chart in Section 13).

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

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

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

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

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

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

**Covered dependent** is a person who is within the class of eligible dependents as set forth in the Eligibility and Enrollment booklet furnished by the Group and has applied to and been accepted by the Group.

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

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

**Deductible** is the amount of covered expenses you must pay before the Plan starts paying.

**Delta Dental** refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. References to Delta Dental as paying claims or issuing benefits means that Delta Dental processes a claim and the Plan Sponsor reimburses Delta Dental any benefit issued. Where this book refers to “we”, “us”, or “our” it is referring to Delta Dental or its employees.

**Dentally Necessary** means services that, in the judgment of Delta Dental:

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

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

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

**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** is any person who is or may become eligible for coverage because of a relationship to a subscriber as set forth in the Eligibility and Enrollment booklet furnished by the Group.

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

a. **Registered Domestic Partner** is a person joined with you in a partnership that has been registered under the laws of any federal, state or local government.
b. **Unregistered Domestic Partner** is a person who has entered into a partnership with you that meets the Group's eligibility criteria.

**Eligible Employee** is an employee or former employee of the Group who meets the eligibility requirements as set forth in the Eligibility and Enrollment booklet furnished by the Group.

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

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

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

**Implant** is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the jawbone and supports a single crown, fixed bridge, or partial or full denture.

**Implant Abutment** is an attachment that connects an implant and an implant supported prosthetic device.

**Implant Supported Prosthetic** is a crown, bridge or removable partial or full denture that is supported by or attached to an implant.

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

**In-Network Delta Dental Premier Dentist** is a licensed dentist who contracts in the Premier network to provide dental care to you.

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

**Maximum Plan Allowance** (MPA) is the maximum amount the Plan will reimburse providers. For a Delta Dental PPO dentist and for out-of-network dentists or dental care providers, the MPA is based on the PPO fee schedule. For a Delta Dental Premier dentist, the MPA is the dentist's filed or contracted fee with Delta Dental. When you use an out-of-network dentist or dental care provider, you will have to pay any amount over the MPA.

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

**Out-of-Network Dentist or Dental Provider** is a licensed dental provider who has not contracted as a Delta Dental PPO dentist or a Delta Dental Premier dentist.

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

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

The **Plan** is the dental benefit plan sponsored and funded by the Group. Delta Dental is contracted to provide its claims and other administrative services.

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

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

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

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

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

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

**Retainer** is a tooth used to support a prosthetic device (bridges, partial dentures or overdentures). Also see **Implant Abutment.**

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

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

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

# SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

## 12.1 MISCELLANEOUS PROVISIONS

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

**Confidentiality of Member Information**
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims. It is also used for referrals , case management and quality management programs. We do not sell your information. The Group's Notice of Privacy Practices has more detail about how we use your PHI. Contact the Group if you have other questions about privacy.

**Right to Collect and Release Needed Information**
You must give us, or authorize a provider to give us, any information we need to pay benefits. We may release to or collect from any person or organization any needed information about you.

**Transfer of Benefits**
Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except to the provider.

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

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

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

**No Waiver**
Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If we delay or fail to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive Delta Dental's rights to enforce the provisions of the Plan.

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

**Responsibility for Quality of Dental Care**
You always have the right to choose your dental provider. Neither the Plan nor Delta Dental is responsible for the quality of your care. Your providers act as independent contractors. Neither the Plan nor Delta Dental can be held liable for the negligence of any dentist providing such services.

**Provider Reimbursements**
Dentists contracting with Delta Dental to provide services to you agree to look only to the Plan for payment of the part of the expense that is covered by the Plan. They may not bill you if the Plan fails to pay the dentist for whatever reason. The dentist may bill you for applicable cost sharing (such as coinsurance or deductible) or non-covered expenses except as may be restricted in the provider contract.

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

**Where any Legal Action Must be Filed**
Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

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

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

**Rescission**
Rescission means canceling (rescinding) coverage back to the effective date, as if it had not existed. The Plan may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation.

Examples of fraud and material misrepresentation include but are not limited to:

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

The Plan has the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. You will be told of a rescission decision 30 days before your coverage is canceled.

## 12.2 ERISA DUTIES

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

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

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

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

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

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

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

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

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

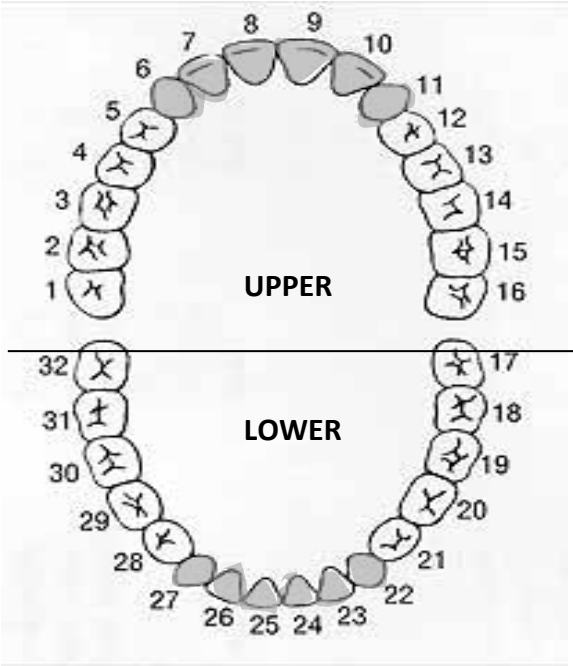
Employee Benefits Security Administration
Seattle District Office, 300 Fifth Ave., Ste. 1110, Seattle, WA 98104
Phone 206-757-6781
Information and assistance is also available through their website: dol.gov/agencies/ebsa

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

## SECTION 13. TOOTH CHART

### THE PERMANENT ARCH

R I G H T




L E F T

Anterior teeth are shaded gray.

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

# Nondiscrimination notice

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

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

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

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### If you need any of the above, call:

888-217-2365 (TDD/TTY 711)

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

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

### Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

**DeltaDentalAK.com | DeltaDentalOR.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. Delta Dental is a trademark of Delta Dental Plans Association.

DELTA DENTAL®

Delta Dental of Oregon & Alaska

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

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

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

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

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

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


For help, call us directly at 833-212-5029
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