Section 2 › Eligibility and residency

To be eligible to apply for one of our Oregon individual dental plans, you must currently reside in the service area for the plan selected, and reside in the service area for six months out of the year. If you had Delta Dental individual dental coverage that ended during the past two years, you won't be eligible unless you have a special enrollment qualifying event or have had continuous group dental coverage since leaving Delta Dental.

☐ **I confirm I meet these requirements.**

Section 3 › Plan selection

I select the following dental plan and deductible for the requested effective date of ___ / ___ / _____ :

☐ Delta Dental PPO – $0 deductible

☒ Delta Dental Exclusive PPO – $0 deductible

☐ Delta Dental PPO Bright Smiles – $0 deductible

If you are changing from one Delta Dental of Oregon individual plan to another outside of open enrollment, any amount applied to the annual maximum plan payment limit will be transferred to your new plan.

Section 4 › Subscriber information

Is this a child- or children-only plan? This section must be completed with subscriber information.

☐ No ☐ Yes. If yes, please list the youngest child as the subscriber.

Children age 26 or older must be on their own policy.

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Language preference

☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP

Mailing address (if different)	City	State	ZIP

Email address (required to go paperless)	Primary phone	Secondary phone

Section 5 > Dependent Information – spouse or registered domestic partner (RDP)

Please complete this section for spouse or RDP to be covered on this dental plan.

Relationship ☐ Spouse ☐ RDP	Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*		Social Security number	Gender ☐ M ☐ F	

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) ____________________

Preferred spoken and written language
☐ English ☐ Spanish ☐ Other (please specify) ____________________

Section 6 > Dependent Information – children

Please list all children to be covered on this dental plan (children must be under age 26 years old). Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

If any children listed above have a different race or primary language than the subscriber, please list their name, race and primary language here.

Section 7 › Other insurance

Will you have other dental insurance?

☐ Yes ☐ No

Section 8 › Credit toward benefit exclusion period (for new dental coverage)

For subscribers and dependents age 19 and over:
Do you have 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the expected effective date of the new policy?

☐ No ☐ Yes. If yes, please provide a letter from your prior carrier or employer documenting the start and end dates of your prior dental coverage. This documentation of prior coverage is required for credit to be applied toward the benefit waiting period. In addition, please provide the following information:

Name of individual(s) enrolled in prior dental plan		
Prior insurance company	Coverage start date *(mm/dd/yyyy)*	Coverage end date *(mm/dd/yyyy)*

Section 9 › Payment method

We offer three payment options for you to choose from.

1. Automatic eBill payment through MyModa.
2. Electronic fund transfer (EFT), see authorization agreement below.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates around the fifth of the month and usually takes one or two days to post to your account. Your initial payment may initiate on a later date if your enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Subscriber		Account holder	
Name of bank	Routing number	Account number	Account type ☐ Checking ☐ Savings

I authorize Delta Dental of Oregon to charge my checking account for monthly premiums for the above named individual. I also authorize my bank, named here, to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Account holder signature	Signature date

Section 10 > Billing options

If you are set up for EFT your premium invoice will be paperless. If you are not set up for EFT you will receive paper invoices in the mail. You may change your billing preference to paperless by going to the eBill section of myModa.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP

Section 11 > Agent of record (to be completed by agent only)

I (the agent) certify that I have explained the eligibility provisions to the subscriber. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Delta Dental. I have informed the subscriber that the effective date of coverage is assigned only by Delta Dental.

For you to become the agent of record, you must be actively appointed with Moda Health/Delta Dental. Please sign and date below.

Agent name	Agency name	Phone	Agent/Agency NPN
Craig Riley	Riley Financial	360·696·3419	138609

Address	City	State	ZIP
601 E. 22nd St.	Vancouver	WA	98663

I certify that the information supplied to me by the subscriber has been truly and accurately recorded.

Agent signature (required)	Signature date

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Section 12 > Basic terms of enrollment

- I understand and agree that this application is not an offer of coverage, and coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
- I understand if my previous policy ended because I did not pay premiums when due, this new coverage may not begin until I have paid my past-due premium amounts from the last 12 months in addition to the first month's premium for this new policy.
- I understand and agree that this application becomes a part of my plan.
- I understand that no benefits are available under this plan for services or supplies that were received prior to the effective date of coverage.
- I understand that acceptance for coverage requires that individuals listed on this application must be residents of the state of Oregon to apply for and maintain coverage under this plan.
- "**Resident**" means a person who lives in the state of Oregon and intends to live in the state permanently or indefinitely. Delta Dental may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- I understand that I may receive benefits that are less than the amount billed by my provider when treatment is not received from a contracted provider.
- I have the right to examine and return the policy within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan rate will renew January 1.
- I have read the Moda privacy statement that is available on modahealth.com.

Section 13 › Go paperless!

You can view your explanation of benefits (EOBs) online by logging in to myModa. After your application is approved, you will receive a welcome letter with your Moda member ID number. With this ID number, simply set up a myModa account by visiting modahealth.com and opt to receive electronic EOBs.

Section 14 › Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, RDP and any dependents over age 18 are required to sign the application.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I have provided these answers as part of the application process required by Delta Dental to enroll in insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Delta Dental may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Delta Dental in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by Delta Dental. If approved, coverage will be in force as of the effective date determined by Delta Dental. Delta Dental may contact me to clarify answers on this application. As the subscriber, I understand I have the right to inspect the information in my file.

I acknowledge that I have read and understand this application, terms and certification and privacy statement.

Print name of responsible party[1] if child- or children-only policy	Relationship[2]
Signature of subscriber ***(if subscriber is under age 18, signature of parent/guardian)***	**Signature date**
Signature of subscriber's legal spouse or RDP, if applying for coverage	**Signature date**
Signature of dependent(s), age 18 and older, if applying for coverage	**Signature date**
Signature of dependent(s), age 18 and older, if applying for coverage	**Signature date**

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

2 *If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.*

Ready to submit? Mail, fax or email this form to Delta Dental.

Mail: Delta Dental/Moda, Membership Accounting, 601 SW Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Delta Dental of Oregon? Visit modahealth.com to log in to myModa and view your member handbook and bill. Once you sign up for myModa and go paperless (see Section 13), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com

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

DELTA DENTAL

Delta Dental of Oregon & Alaska

View our plans at shopmodaplans.com.
Questions? We're here to help. Call us at 855-718-1767.

2019 | Individual dental plan application

for Oregon individuals and families

Please fill out all sections of this application and send it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you. We must receive your complete application before the requested effective date. For special enrollment, we must receive this application and supporting documentation within 60 days of the special enrollment event date. Your application process could be delayed or denied if supporting documentation is not provided.

Section 1 > Application type

The reason I am applying or making a change is:

Open enrollment

- ☐ New policy/subscriber
- ☐ Add dependent to existing plan
- ☐ Plan change only

Existing Delta Dental subscriber name
Existing subscriber ID

Special enrollment

Date of event *(mm/dd/yyyy)*

- ☐ Marriage or registered domestic partnership (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Placement of foster child
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or RDP
- ☐ Loss of eligibility for group coverage
- ☐ COBRA ended due to expiration of coverage
- ☐ Other

Your completed application must include proof of the life event that made you eligible for a special enrollment. Your application process could be delayed or denied if supporting documentation is not provided.

A list of acceptable documentation to support your life event can be found at modahealth.com/shop/special-enrollment.

You will need a special enrollment event for changes or new policies made outside of the open enrollment period.

If you are enrolling due to a special enrollment event and want a later effective date, please note the requested effective date here *(mm/dd/yyyy)*

2019 Dental plan benefit table

Calendar year costs	[redacted]											
	Ages 0 – 18		Ages 19+		Ages 0 – 18		Ages 19+		Ages 0 – 18		Ages 19+	
	In-network, you pay	Out-of-network, you pay	In-network, you pay	Out-of-network, you pay	In-network, you pay	Out-of-network, you pay	In-network, you pay	Out-of-network, you pay	In-network, you pay	Out-of-network, you pay	In-network, you pay	Out-of-network, you pay
Deductible per person	$0				$0				$0			
Out-of-pocket max per person (ages 0 – 18)	$350 for one member / $700 for two or more members (in-network only)				$350 for one member / $700 for two or more members (in-network only)				$350 for one member / $700 for two or more members (in-network only)			
Annual benefit max (age 19+)	$1,000				$1,500				N/A			
Class 1												
Exams and X-rays	10%	50%	25%	50%	10%	Not covered	0%	Not covered	10%	50%	Not covered	
Cleanings	10%	50%	25%	50%	10%	Not covered	0%	Not covered	10%	50%	Not covered	
Periodontal maintenance	10%	50%	25%	50%	10%	Not covered	0%	Not covered	10%	50%	Not covered	
Sealants	10%	50%	25%	50%	10%	Not covered	0%	Not covered	10%	50%	Not covered	
Topical fluoride	10%	50%	25%[1]	50%[1]	10%	Not covered	0%[1]	Not covered	10%	50%	Not covered	
Class 2												
Space maintainers	75%	75%	Not covered	Not covered	30%	Not covered	Not covered	Not covered	70%	70%	Not covered	
Restorative fillings[2]	75%	75%	40%	50%	30%	Not covered	30%	Not covered	70%	70%	Not covered	
Class 3												
Oral surgery[3]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Endodontics[3]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Periodontics[3]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Restorative crowns[4]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Bridges[3]	Not covered	Not covered	50%	50%	Not covered	Not covered	50%	Not covered	Not covered	Not covered	Not covered	
Partial and complete dentures[3]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Anesthesia[3]	75%	75%	50%	50%	50%	Not covered	50%	Not covered	70%	70%	Not covered	
Orthodontia[4]	75%	75%	Not covered	Not covered	50%	Not covered	Not covered	Not covered	70%	70%	Not covered	
Features												
Provider network	Delta Dental PPO Network	All other providers	Delta Dental PPO Network	All other providers	Delta Dental PPO Network	All other providers	Delta Dental PPO Network	All other providers	Delta Dental PPO Network	All other providers	All other providers	
Balance bill	Delta Dental PPO Network: No	Delta Dental Premier Network: No Nonparticipating: Yes	Delta Dental PPO Network: No	Delta Dental Premier Network: No Nonparticipating: Yes	Delta Dental PPO Network: No	Yes	Delta Dental PPO Network: No	Yes	Delta Dental PPO Network: No	Delta Dental Premier Network: No Nonparticipating: Yes	Yes	

1 *Covered once in a 12 month period if there is recent history of periodontal surgery or high risk of decay because of medical disease or chemotherapy or similar type of treatment.*

2 *Six-month exclusion period for ages 19 and over if member does not have 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the effective date of the 2019 Delta Dental policy.*

3 *12-month exclusion period for ages 19 and over if member does not have 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the effective date of the 2019 Delta Dental policy.*

4 *Only medically necessary orthodontia to treat cleft palate is covered.*

These benefits and Delta Dental of Oregon policies are subject to change in order to be compliant with state and federal guidelines. This brochure provides summaries of various health plans and is not a contract. If there is any discrepancy between the summaries and the contract, it is the contract that will control.

Limitations and exclusions for dental plans

These are some common limitations and exclusions for our 2019 Delta Dental of Oregon individual and family dental plans. For a full list of limitations and exclusions per plan or for copies of plan summaries, please see back cover for our sales and service team contact information.

Limitations

Class 1

- Bitewing X-rays once in a 12-month period
- Exam once in a six-month period
- Fluoride once in a six-month period under age 19 and once every 12 months if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment for age 19+
- Full-mouth or panoramic X-rays once in a five-year period
- Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year.
- Sealants limited to unrestored occlusal surface of permanent molars once per tooth in a five-year period except for evidence of clinical failure

Class 2 and Class 3

- Athletic mouth guard covered once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over
- Bridges once in a seven-year period age 19 and over
- Crowns and other cast restorations once in a seven-year period
- Crown over implant once per lifetime per tooth.
- Dentures once in a seven-year period age 16 and over
- IV sedation or general anesthesia only with surgical procedures. Oral anesthesia only for members under age 19 used during an in-office procedure.
- Night guard (occlusal guard) covered at 100 percent once in a five year period, up to $150 maximum. Repair and reline of occlusal guard are covered once every 12-month period. One occlusal guard adjustment is covered every 12-month period.
- Scaling and root planing is limited to once per quadrant in any 2-year period
- Porcelain crowns on back teeth are limited to the amount for a full metal crown.

Exclusions

- Anesthetics, analgesics, hypnosis and most medications, including nitrous oxide for adults
- Charges above the maximum plan allowance
- Charting (including periodontal, gnathologic)
- Congenital or developmental malformations
- Cosmetic services
- Duplication and interpretation of X-rays
- Experimental or investigational treatment
- Hospital costs or other fees for facility or home care except for emergency care for members under age 19
- Implants
- Instructions or training (including plaque control and oral hygiene or dietary instruction)
- Orthodontia (exception for treatment of cleft palate under age 19)
- Over-the-counter night guards and athletic mouth guards
- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Temporomandibular joint syndrome (TMJ)
- Treatment not dentally necessary

Calculate what you pay each month

Our plans offer competitive premiums -- the amount you pay each month for coverage. If you want great benefits and value, you're in good hands.

What affects your premium?

The plan, your age and the ages of your dependents may affect your premium amount. If you have more than three dependents under age 21 on the plan, you will only be charged a premium for the first three. Child dependents ages 21 through 25 have a premium based on their actual age.

How your premium could change

2019 premiums are effective Jan. 1, 2019, through Dec. 31, 2019. Your premium could change during the plan year if you add a family member through a special enrollment. If that happens, in most cases the new premium is effective the first of the month following the special enrollment event. Your premium may also change if you remove a family member.

Having a birthday during a plan year won't affect your current premium. When you renew your plan in January, your premium will reflect the current plan amount for your age.

Yearly premium updates

We adjust premiums for individual and family plans each year. You'll receive a renewal notice prior to the new plan effective date explaining any changes to your plan and premium.

Dental plan premiums

These premiums apply to members who live anywhere in Oregon.

Plan name	Age 0 – 20	Age 21 – 59	Age 60+
Delta Dental PPO℠	$37	$34	$43
Delta Dental Exclusive PPO	$39	$37	$46
Delta Dental PPO Bright Smiles	$37 (age 18 and under only)	$0 (no benefits)	$0 (no benefits)

Premiums effective Jan. 1, 2019 through Dec. 31, 2019