DELTA DENTAL®

2024

Alaska Group Dental Plan

Local Union 598 Plumbers & Pipefitting H&W Fund
Delta Dental PPO Preventive First
Group #10019278
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SECTION 1. WELCOME TO DELTA DENTAL OF ALASKA

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 of Alaska (abbreviated as 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). 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 of Alaska to provide claims and other administrative services.

This handbook will give you important information about the Plan's benefits, limitations and procedures.

If you have questions, call one of the telephone numbers listed in section 2.1 or use tools and resources on your Member Dashboard at www.DeltaDentalAK.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 e-mail 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 the **Member Dashboard**)
www.DeltaDentalAK.com
Includes many helpful features, such as Find Care (use to locate an in-network dentist)

Dental Customer Service Department
Toll-free 888-374-8906
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
Delta Dental PPO
Delta Dental Premier

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

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 from the Delta Dental Premier or Delta Dental PPO Directory (available on your Member Dashboard using Find Care), all of the paperwork takes place between the dentist's office and us. Delta Dental Plans Association provides offices and/or contacts in every state.

If you need dental care, you may go to any dental office. There are differences in how the Plan pays for Delta Dental for Delta Dental PPO dentists, Delta Dental Premier (contracted with the Delta Dental Premier network) 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

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 percentage of reimbursement amount (as defined in section 11). If you do not have reasonable access (within 50 miles) to an in-network Delta Dental PPO dentist we will pay for services from an out-of-network dentist in Alaska at the in-network benefit level. The reimbursement amount is the amount for out-of-network dentists. You may have to pay the difference between the reimbursement 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

The Plan covers the services listed when performed by a dentist or dental care provider (licensed hygienist or denturist). 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 reimbursement amount. Benefits will never be paid for services that are beyond the scope of a dentist's or dental care provider's license, certification 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.

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: $50
Per member (not to exceed $150 per family) per year, or portion thereof
Deductible applies to covered Class II and Class III services

Annual maximum plan payment limit: $3,000
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: DIAGNOSTIC AND PREVENTIVE SERVICES
COVERED SERVICES PAID AT 100% OF THE REIMBURSEMENT AMOUNT

4.1.1 Diagnostic

a. Diagnostic Services:
i. Exam
ii. Consultations for covered dental procedures
iii. Intra-oral x-rays to assist in determining required dental treatment

a. Diagnostic Limitations:
i. Periodic (routine) or 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 only covered if you are under age 12.
iii. Topical application of fluoride is covered once in any 6-month period if you are age 18 and under. If you are age 19 and over, topical application of fluoride is covered once in any 6-month period if you have a recent history of periodontal surgery or 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 once per space. Space maintainers for primary anterior teeth, missing permanent teeth or if you are age 14 or over are not covered.

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

4.2 CLASS II: BASIC SERVICES
COVERED SERVICES PAID AT 80% OF THE REIMBURSEMENT AMOUNT

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 if you are age 19 and over.

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 24 months 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 surgical 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.
iv. Retreatment of the same tooth, by the same dentist within 2 years 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 following 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 and, if you are age 19 and over, 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 a covered surgical procedure done in a dental office
ii. When necessary due to concurrent medical conditions

4.3 CLASS III: MAJOR SERVICES

COVERED SERVICES PAID AT 80% OF THE REIMBURSEMENT AMOUNT

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
ii. Stainless steel crowns

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 5-year period on any tooth. See section 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. Coverage is limited to gold without porcelain, and you must pay the difference.
iii. If your tooth can be restored with a material such as a 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 for repair of a restoration done within 2 years of the original restoration is not covered if you are age 19 and over.
vi. Re-cement or re-bond of a crown, onlay 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. Tissue conditioning
vi. Implants and implant maintenance
vii. Surgical stent in conjunction with a covered surgical procedure

b. Prosthodontic Limitations:

i. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
ii. Partial dentures: A temporary (interim) partial denture is only covered when placed within 2 months of the extraction of an anterior tooth or to replace missing anterior permanent teeth of members for age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. Cast restorations for partial denture retainer teeth are not covered unless the tooth requires a cast restoration because it is decayed or broken.
iii. 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.
iv. Tissue conditioning is covered no more than twice per denture in a 3-year period.
v. Surgical placement and removal of implants are covered. 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 also covers these services:
    A. The final crown and abutment over a single implant.
    B. An alternate benefit per arch of a full or partial denture for the final implant-supported prosthetic 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. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
    D. You are not eligible for these benefits or alternate benefit if we paid a cast restoration or prosthodontic benefit, including a pontic, for the tooth, implant or tooth space within the previous 7 years.
vi. Re-cementing or re-bonding an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.
vii. 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.
viii. 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. Over-the-counter mouthguards are not covered.
ii. A nightguard (occlusal guard) is covered once per year between ages 13 and 19 at 100% and once every 5 years at 100% up to $250 maximum for ages 19 and over with no deductible. Over-the-counter occlusal guards are not covered.
iii. Repair or reline and adjustment of occlusal guards are covered once in any 12-month period.

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 reimbursement amount for the least costly treatment. You will have to pay the rest of the dentist's fee.

4.5 Intellectual and Developmental Disabilities

For members with intellectual or developmental disabilities, we cover some extra services to help them get the dental care they need:

a. Visits before the first treatment, to help members learn what to expect
b. Up to 2 extra cleanings per year
c. Silver diamine fluoride to stop the progression of cavities for members who cannot tolerate the use of certain dental instruments
d. Dental case management for members with special healthcare needs (such as sensory issues, behavioral challenges, severe anxiety) that make dental care difficult

Call Customer Service to find out how to get these extra benefits.

SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the 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.

SECTION 6. ORTHODONTIC BENEFIT

Orthodontic services are defined as the procedures of treatment for correcting malocclusion of teeth.

6.1 ORTHODONTIC BENEFIT

Orthodontic services, including placement of a device to facilitate eruption of an impacted tooth, are a benefit.

The Plan will pay 50% of the reimbursement amount for orthodontic services up to the orthodontic lifetime maximum of $2,000 per member. This lifetime maximum is not included in the dental plan maximum payment limit. If the Plan has a deductible, it does not apply to orthodontic services.

6.2 LIMITATIONS

Self-administered orthodontic services are not covered.

Delta Dental's obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility or termination of the Plan.

If treatment began before you were eligible for orthodontic services under the Plan, we will base the Plan's obligation on the balance of the orthodontist's normal payment pattern. The orthodontic maximum will apply to this amount.

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 recommended, referred or provided by a dentist or dental care provider.

Anesthesia or Sedation
General anesthesia and/or IV sedation except as stated in section 4.2.6

Anesthetics, Analgesics, Hypnosis, and Medications
Including nitrous oxide local anesthetics or any other prescribed drugs

Behavior Management
Additional services, time or assistance to control the actions of a member (except as stated in section 4.5)

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

Claims Not Submitted Timely
Claims submitted more than 12 months after the date of service

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 primary 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, state approved community health and developmental disabilities program, extended care facility or home care treatment, except for emergency care

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

Illegal Acts, Riot, Rebellion or War

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 4.3.5

Missed Appointment Charges

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

Over-the-Counter
Including over the counter occlusal guards (nightguards) and athletic mouthguards.

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

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

Rebuilding or Maintaining Chewing Surfaces; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except an occlusal guard (nightguard) as provided for in section 4.2.8. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

Self Treatment
Services you provides 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 9.3.2)

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 or participating employer 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. ELIGIBILITY & ENROLLMENT

Eligibility and enrollment rules are set forth in any applicable bargaining agreement or as determined by the employer. Contact the Health Trust for details.

You must notify the Health Trust or participating employer and Delta Dental of any change of address.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 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 exception is absence of legal capacity

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.

9.1.1 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 reimbursement amount 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 9.1.

9.1.2 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.

9.1.3 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 within 30 days. We will finish processing the claim and send an EOB to you no more than 45 days after we receive it.
c. If we need more information, we will send you a notice describing 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 or 30 days of the original receipt of the claim.

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 9.1.

9.2 COMPLAINTS & APPEALS

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

9.2.1 Time Limit for Submitting Appeals and Complaints

If your appeal or complaint is not on time, you may lose the right to any appeal or complaint.

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.

9.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and an optional second level appeal. If you are not satisfied with the result of the first level appeal, and the dispute meets the specifications outlined in the respective sections, you may ask for a second level appeal (section 9.2.5).

You may review the claim file and submit evidence to support your appeal. You may choose a person (representative) to act on your behalf.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time. If you need help, ask Customer Service
b. The Board of Trustees, as the Plan Administrator and Health Trust Administrator who were not involved in the original decision will investigate your appeal
c. We will send the decision to you within 30 days. The notice on a decision regarding a utilization review issue will include the right to file a voluntary second level appeal.

The Health Trust Administrator will send the decision to you. If applicable, the notice will include information on the right to file a lawsuit under ERISA Section 502(a).

If you choose to ask for a second level appeal, any statute of limitation or timeline affecting your rights to additional review, such as filing a lawsuit under ERISA Section 502(a), will not start until the second level appeal decision is made.

If you choose not to pursue the second level appeal, the Plan waive any right to assert that you failed to exhaust the Plan's internal review process should you elect to file a lawsuit in court under ERISA Section 502(a) following the first level appeal.

Special Circumstances

The timelines addressed 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

9.2.3 Definitions

For purposes of section 9.2, 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

Complaint is an expression of dissatisfaction to us about any matter not involving an appeal or adverse benefit determination. Complaints may involve access to providers, waiting times, demeanor of dental care personnel, adequacy of facilities and quality of dental care.

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 judgment

9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.3.1 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, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

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.

9.3.1.1 When this Plan Pays First

When another plan does not have a COB provision, that plan is primary. When another plan does have a COB provision, 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.

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

If the primary plan is a closed panel plan (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.

9.3.1.3 Definitions

For purposes of section 9.3.1, the following definitions apply:

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

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

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

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

Plan does not include:

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

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

These are not allowable expenses:

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

If a plan benefit has a visit or dollar paid limitation and the limitation has been met, services in excess of the limitation will not be considered allowable expenses for the purpose of this provision.

9.3.2 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 in full for any benefits paid that are or may be recoverable from a third party or other source, no matter how the recovery is characterized.

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 along with the Plan Administrator 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 any actions that will help us recover costs from a third party.

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 true 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 healthcare expenses are itemized or expressly excluded in the third party recovery.

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

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.3.2.

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 9.3.2 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by us.

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

SECTION 10. CONTINUATION OF DENTAL COVERAGE

Check with the Plan Administrator to find out if you qualify for continuation coverage.

SECTION 11. DEFINITIONS

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is most commonly done in conjunction with the removal of a tooth or teeth so the gums heal smoothly for the placement of partial or full dentures.

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 12).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 12).

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

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

Calendar Year is a period beginning January 1st and ending December 31st. See section 4 (Benefits and Limitations)

Cast Restoration includes crowns, 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 the 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 Expense is the 80th percentile of those fees usually charged for a given service by dentists in a given region. This should be the market rate fee for the service. If the database does not contain a fee for a particular procedure in a particular region the fee is based on the covered expense of a comparable service.

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

Debridement is the removal of excess plaque. It is 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 of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service, a not-for-profit health insurer licensed in Alaska. 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 ay 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 under the terms of the Plan because of their relationship to the subscriber.

Eligible Employee is any employee or former employee of the Group who has met the eligibility requirements to be enrolled on the Plan (see section 7.1).

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

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

Implant is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone 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 refers to dentists or services provided by dentists who are contracted in-network Delta Dental PPO dentists or who are contracted in the Delta Dental Premier network.

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

Member is the subscriber, dependent of a subscriber or a person otherwise eligible for the Plan 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.

Non-Participating Dentist or Dental Provider is a licensed dental provider who has not contracted as a participating Delta Dental PPO provider or Delta Dental Premier dentist.

Out-of-network is a licensed dental providers, or services provided by licensed dental providers, who are not contracted as in-network Delta Dental PPO dentists or who are not contracted dentists in the Delta Dental Premier network.

Participating Employer refers to an individual employer that:

a. is considered a member company of the Group
b. is considered a member in good standing
c. is actively engaged in business that employs employees who are enrolled according to the requirements of the Group's Plan

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.

Plan Sponsor is the Group.

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

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

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

Prophylaxis is cleaning and polishing of all teeth.

Reimbursement Amount is the maximum amount the Plan will reimburse providers. For a Delta Dental PPO dentist, this amount is the lesser of the covered expense, the fee in the PPO fee schedule or the dentist's billed charge. For Delta Dental Premier dentists, this amount is the lesser of the covered expense, the provider's accepted filed fee with Delta Dental, or the dentist's billed charge. For non-participating dentists, this amount is the lesser of 75% of the covered expense or the provider's billed charge. When you use a non-participating dentist, you will have to pay the difference between the reimbursement amount and the actual charge.

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 fillings and crowns.

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

Service Area is the geographical area where Delta Dental PPO services are provided.

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 & 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 except to the provider.

Correction of Payments or Recovery of Benefits Paid
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 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, participating employers 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, participating employer or the member, a copy of which has been given to the Group, participating employer 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 member's agent for all purposes under the Plan. The Group is not the agent of Delta Dental.

Responsibility for Quality of 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. Delta Dental and participating dentists act as independent contractors. The dentist is solely responsible for the dental care provided to you. Delta Dental does not control the detail, manner or methods by which a participating dentist provides care. Neither the Plan nor Delta Dental can be held liable for the negligence of any dentist providing services to you.

Provider Reimbursements
Providers 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 provider for whatever reason. The provider may bill you for member 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 Alaska.

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 Alaska.

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 9.1). 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.

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 participating employer if this section applies to your Plan.

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

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

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of the 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 9.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the

court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds the claim is frivolous).

Assistance with Questions
For questions about section 13 or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

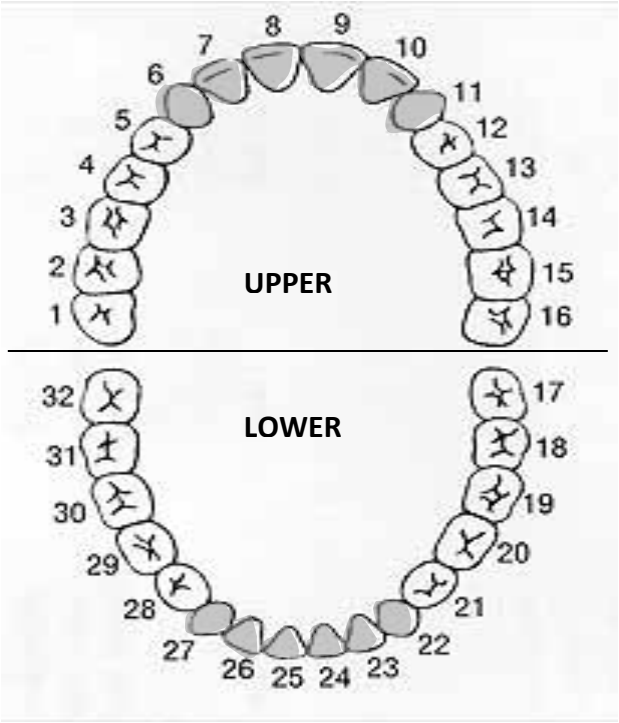
Employee Benefits Security Administration
Seattle District Office,
300 Fifth Ave., Ste. 1110,
Seattle, WA 98104
206-757-6781
Information and assistance is also available through their website: www.dol.gov/agencies/ebsa.

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

SECTION 13. TOOTH CHART

THE PERMANENT ARCH

RIGHT



LEFT

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)

SECTION 14. EXAMPLE OF HOW THE PLAN PAYS

In this example, this Plan pays 80% of the reimbursement amount.

Billed charge	Covered expense	Reimbursement amount	Percentage paid by the Plan	Amount paid by the Plan	Percentage paid by the member	Balance bill	Member responsibility
Delta Dental PPO In-network dentists Delta Dental Premier dentists							
$200	$180	$140	80%	$112	20%	None	$28
Nonparticipating dentists							
$200	$180	$180	60%	$108	40%	$20	$92

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2365 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

DeltaDentalAK.com | DeltaDentalOR.com

2688-NDS-DD (06/23)

DeltaAKLGASObk 1-1-2024

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 888-374-8906
(En español: 877-299-9063)

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