DELTA DENTAL®

2023

Alaska Group Dental Plan

ASEA/AFSCME Local 52 HEALTH BENEFITS TRUST
Delta Dental PPO Preventive First
Group # 10019391
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SECTION 1. WELCOME

This handbook describes 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 of Alaska to provide claims and other administrative services.

Members may direct questions to one of the telephone numbers listed in section 2.1 or access tools and resources on Delta Dental's personalized member website, the Member Dashboard, at www.DeltaDentalAK.com. The Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

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

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to the Member Dashboard)
www.DeltaDentalAK.com/ASEA
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 of Alaska
P.O. Box 40384
Portland, Oregon 97240

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to the Member Dashboard or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK

See Network Information (section 3.1) for details about how the network works.

Dental network
Delta Dental PPO
Delta Dental Premier

2.4 OTHER RESOURCES

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

SECTION 3. USING THE PLAN

For questions about the Plan, members should contact Customer Service. This handbook describes the benefits of the Plan. It is the member's responsibility to review this handbook carefully and to be aware of the Plan's limitations and exclusions.

At a first appointment, members should tell the dentist that they have dental benefits administered by Delta Dental. Members will need to provide their subscriber identification number and Delta Dental group number to the dentist. These numbers are located on the ID card.

3.1 NETWORK INFORMATION

Delta Dental plans offer access to the largest dental network in Alaska and one of the largest networks across the nation. The Delta Dental PPO plan is designed for members in the Anchorage, Fairbanks North Star Borough, and Matanuska-Susitna (Matsu Valley) service areas and is easy to use and cost effective. This plan offers the same annual maximum plan payment limit, deductibles, and coinsurance whether a member sees an in-network dentist (Delta Dental PPO or Delta Dental Premier) or an out-of-network dentist.

If members choose an in-network dentist from the Delta Dental Premier or Delta Dental PPO Directory (available on the Member Dashboard using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. For travelers outside Alaska, Delta Dental Plans Association provides offices and/or contacts in every state. Subscribers who move outside of the service area must contact Customer Service for assistance.

Members needing dental care may go to any dental office. However, there are differences in reimbursement by the Plan for Delta Dental PPO dentists, Delta Dental Premier (contracted with the Delta Dental Premier network) dentists and out-of-network dentists. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

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 limited to the applicable percentages of reimbursement amount specified in Section 4. Services received from out-of-network dentists in Alaska when there is no reasonable access (within 50 miles) to an in-network Delta Dental PPO dentist will be covered at the in-network percentage. The reimbursement amount will continue to be the amount described in Section 4 for out-of-network dentists.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current benefits and returned to the dentist. The member and their 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), and only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. Delta Dental's dental consultants and dental director determine these standards.

Payment of covered expenses is always limited to the reimbursement amount. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certification or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

Covered dental services are outlined 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 on a plan year basis (the period, or portion thereof, commencing July, 1st of any calendar year and ending June, 30th of the subsequent calendar year). Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

	Plan A Full Plan for Employee and Family	**Plan B** Full Plan for Employee Only	**Plan C** Supplemental Plan for Employee and Family with other coverage	**Plan D** Low Option Plan for Employee and Family
Annual Deductible				
Per member	$25	$25	$25	Not covered
Per family	$75		$75	
Percentage of Reimbursement				
Class I Preventive	100%	100%	100%	Not covered
Class II Basic	85%	85%	85%	
Class III Major	50%	50%	50%	
Annual Maximum Applies to Class II Basic and Class III Major services except orthodontia.	$2,000	$2,000	$2000	Not covered
Members are responsible for expenses that exceed 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.** Examination
- **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 examinations (including problem focused comprehensive examinations) or consultations are covered twice per plan year.
ii. Limited examinations 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 for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
vi. Only the following 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 plan year*. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year.
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered for all ages.
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars.
vi. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

*Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (Section 5).

4.2 CLASS II: BASIC SERVICES

COVERED SERVICES PAID AT 85% OF THE REIMBURSEMENT AMOUNT

4.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings for the treatment of decay
ii. Stainless steel crowns

b. Restorative Limitations:

i. Restorations within 2 months of interim caries arresting medicament application are not covered for members age 19 and over.
ii. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided.
iii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit 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. A separate charge for nitrous oxide, general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.
vi. 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.
vii. Additional limitations when teeth are restored with crowns or cast restorations are in section 4.3.1

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 in conjunction 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 the 30 days following an oral surgery is not covered. Post-operative care is included in the charge for original surgery.
iv. Brush biopsy is covered twice per year. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

4.2.3 Endodontic

a. Endodontic Services:

i. Procedures for treatment of 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. Cost of retreatment of the same tooth, by the same dentist within 2 years of a root canal is not eligible for additional coverage. 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, for members age 19 and above, only if there has been no cleaning (prophylaxis, periodontal maintenance) within 2 years.

4.2.5 Prosthodontic

a. Prosthodontic Services:

i. Denture relines
ii. Repair of an existing prosthetic device

b. Prosthodontic Limitations:

i. Denture repairs and relines: A separate, additional charge for denture repairs done within 6 months after the initial placement is not covered.

4.2.6 Anesthesia

a. Anesthesia Services:

i. General anesthesia or IV sedation
ii. Nitrous oxide

b. Anesthesia Limitations:

General anesthesia or IV sedation is covered only:

i. In conjunction with a covered surgical procedure performed in a dental office

ii. When necessary due to concurrent medical conditions
iii. Nitrous oxide is covered in conjunction with a covered dental procedure performed in a dental office.

4.3 CLASS III: MAJOR SERVICES

COVERED SERVICES PAID AT 50% OF THE REIMBURSEMENT AMOUNT

Note: Class III prosthetic services are paid on the seat date.

4.3.1 Restorative

a. Restorative Services:
i. Cast restorations, such as crowns, inlays, 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 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 the member is responsible for paying the difference.
iii. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit 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 for members age 19 and over.
vi. Re-cement or re-bond of a crown, inlay, 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. Tissue conditioning
iv. Implants and implant maintenance
v. Surgical stent in conjunction with a covered surgical procedure

b. Prosthodontic Limitations:
i. A bridge or a full or partial denture will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 5 years.
ii. 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.

iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members 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. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
iv. Denture adjustments and relines: A separate, additional charge for denture adjustments 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 abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
    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; or
    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 one or more of the retainers is supported by a natural tooth.
    E. These benefits or alternate benefits are 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. The re-cement or re-bond of 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. The member is responsible for paying the difference.
ix. Prosthodontics are not covered within 2 months of interim caries arresting medicament application for members age 19 and over.

4.3.3 Other

a. Other Services:
i. Night guard (occlusal guard)
ii. Athletic mouthguard
iii. Orthodontia, including placement of a device to facilitate eruption of an impacted tooth, for correcting malocclusioned teeth when necessity is established through an in-person clinical examination of the member

b. Other Limitations:

i. A night guard (occlusal guard) is covered once per year between ages 13 and 19 and once every 5 years for ages 19 and over with no deductible. Over-the-counter occlusal guards are not covered.
ii. Repair or reline and adjustment of occlusal guards are covered once in any 12-month period
iii. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period age 16 and over. Over-the-counter mouthguards are not covered.

4.4 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the reimbursement amount for the least costly treatment. The member will be responsible for the remainder of the dentist's fee.

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

This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in 4.1.2.

5.1.1 Diabetes

For members with diabetes, elevated blood sugar levels can have a negative effect on 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 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 the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease 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. Furthermore, data also suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of when they had a previous cleaning.

5.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on the Member Dashboard. Members with diabetes 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 $1,500 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.

The Plan'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 the member was eligible for orthodontic services, the Plan will base its obligation on the balance of the orthodontist's normal payment pattern. The orthodontic maximum will apply to this amount.

SECTION 7. EXCLUSIONS

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

Anesthesia or Sedation
General anesthesia and/or IV sedation except as stated in section 4.2.5

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

Behavior Management

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
Including, treatment of 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
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

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

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

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

Illegal Acts, Riot, Rebellion or War
Services and supplies for treatment of an injury or condition caused by or arising directly from a member's illegal act. This includes any expense caused by or arising out of illegal acts related to riot, declared or undeclared war, including civil war, martial law, insurrection, revolution,

invasion, bombardment or any use of military force, or usurped power by any government, military or other authority.

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

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 for surgical stents as stated in section 4.3.2

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 (night guards) 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 (night guard) as provided for in section 4.3.3. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

Self Treatment
Services provided by members to themselves

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

Services on Tongue, Lip or Cheek

Services Otherwise Available
Including those services or supplies:

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

Taxes

Teledentistry Fees
A separate charge for teledentistry is not covered. Teledentistry is included in the fees for overall patient management

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

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

Translation and Sign Language Services
Included in the fees for overall patient management and are not covered as a separate benefit

Treatment After Coverage Terminates
Except for cast restoration and prosthodontic services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends. This exception is not applicable if the Group or participating employer transfers its plan to another administrator.

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

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

Treatment of Closed Fractures

SECTION 8. ELIGIBILITY

Plan B is for employees only. Dependent children, spouses, and domestic partners are not covered. Disregard any reference to dependents, spouses, domestic partners or children.

The date a person becomes eligible may be different than the date coverage begins (see section 9.5).

8.1 SUBSCRIBER

A person is eligible to enroll in the Plan if the person:

a. resides in the PPO service area if enrolling in a PPO plan
b. is a permanent documented full time employee. An eligible employee includes sole proprietors, partners of a partnership or an independent contractor if the sole proprietor, partner or independent contractor is included as an employee under the Plan
c. is not a leased, seasonal, substitute, or temporary employee, or an agent or consultant
d. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security (a sole proprietor, owner, business partner or independent contractor may be considered an eligible employee if they have federal taxes deducted from any income related to the Group's business)
e. works on a regularly schedule basis the specified hours per week as required by the Group
f. satisfies any cumulative hours of service requirement and orientation and/or eligibility waiting period

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

8.2 DEPENDENTS

A subscriber's legal spouse is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Foster children are eligible only while legally a foster child.

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

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

A subscriber's child who has sustained a disability making the child physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though the child is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Eligibility will be

determined based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Relevant recent hospitalization records (e.g., history and physical, discharge summary)
d. Disability information from prior carrier

A determination will be made based on documentation of the child's medical condition. Periodic review will be required unless the disability is certified to be permanent.

8.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

8.4 NEW DEPENDENTS

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

If a subscriber marries, the spouse and their children are eligible to enroll as of the date of the marriage.

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

SECTION 9. ENROLLMENT

9.1 ENROLLING ELIGIBLE EMPLOYEES

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

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

9.2 ENROLLING NEW DEPENDENTS

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

9.3 OPEN ENROLLMENT

Eligible employees and/or any eligible dependents who are not enrolled within 31 days of first becoming eligible must wait for the next open enrollment period to enroll unless:

a. The person meets one of the eligibility requirements described in section 9.4.1
b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's dental plan and request for enrollment is made within 30 days after the court order is issued.

Open enrollment occurs once a year at renewal.

9.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights described in sections 9.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy
c. To both an eligible employee and their dependent(s) if neither is enrolled under the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

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

9.4.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other dental coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

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

9.4.2 Eligibility for Premium Subsidy

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

9.4.3 New Dependents

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

9.5 WHEN COVERAGE BEGINS

Coverage for subscribers begins on the date determined by the group after a waiting period and any cumulative hours of service or orientation period, as shown below.

Coverage begins on the day a subscriber becomes eligible to apply if that is the first day of a month. For subscribers becoming eligible to apply after the first day of a month, coverage begins on the first day of the following month.

Coverage for new dependents through marriage with the Group begins on the first day of the month if the marriage is the first day of the month. Otherwise, coverage begins the first day of the month following the date of marriage.

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

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

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

9.6 WHEN COVERAGE ENDS

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

9.6.1 Termination of the Group Plan or of a Participating Employer's Participation in the Plan

Coverage ends for the Group or participating employer and members on the date the Plan or participation in the Plan ends.

9.6.2 Termination by Subscriber

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

9.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see Section 12). The Group must notify Delta Dental of any continuation of coverage, and appropriate premiums must be paid along with the participating employer's regular monthly payment.

9.6.4 Termination, Layoff or Reduction in Hours of Employment

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

If a subscriber

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

And within 6 months the subscriber

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

The subscriber and any eligible dependents may enroll in the Plan on the date of rehire or the date the subscriber works enough hours to qualify, and coverage will begin on that date. Any exclusion period required by the Plan will not have to be re-served. All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage.

9.6.5 Loss of Eligibility by Dependent

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

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), or date of legal separation.
b. Coverage ends for an enrolled child on the last day of the month in which
    i. the child turns age 26
    ii. the grandchild's parent is no longer a covered dependent of the subscriber
    iii. stepchild relationship ends due to divorce
    iv. legal guardianship or foster child relationship ends.

The subscriber must notify the Group and Delta Dental when a marriage or foster child relationship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends.

9.6.6 Rescission

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time, for fraud, material misrepresentation, or concealment by the member. This may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and oral or written falsification or alteration of claims, including omission of information. The Plan reserves the right to retain premiums paid as reimbursement for benefits paid by the Plan, and the member shall be responsible for any remaining balance of benefits paid. If coverage ends under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of any affiliates.

9.6.7 Continuing Coverage

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

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION & PAYMENT OF CLAIMS

10.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred.

10.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through the Member Dashboard. The EOB will show if a claim has been paid, denied or accumulated toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.1.

10.1.3 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. Delta Dental will respond to an inquiry within 30 days of receipt.

10.1.4 Time Frames for Processing Claims

For claims that do not require additional information, the Plan will pay or deny the claim, and an EOB will be sent to the member within 30 days after receiving the claim.

If additional time is needed to process the claim for reasons beyond Delta Dental's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then complete its processing and send an EOB to the member no more than 45 days after receiving the claim. If more information is needed to complete processing of the claim, a notice will be sent describing the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is also subject to the Plan's claim submission period explained in section 10.1.1.

10.2 COMPLAINTS & APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

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

Appeal is a request by a member or their representative for Delta Dental to review an adverse benefit determination.

Appointed or Authorized Representative is a person appointed or authorized to represent a member in filing an appeal or complaint. A member may appoint any person (relative, friend, advocate, attorney or physician). A surrogate may be authorized by the court or act in accordance with state law on behalf of the member (court-appointed guardian, one with Durable Power of Attorney, healthcare proxy or person designated under a healthcare consent statute).

Complaint means an expression of dissatisfaction to Delta Dental 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 means a system of reviewing the dental necessity, appropriateness, or quality of dental care services and supplies using specified guidelines and retrospective review. An adverse benefit determination that the item or service is not dentally necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved judgment of a dental consultant is a utilization review decision.

10.2.2 Time Limit for Submitting Appeals and Complaints

Members have **180 days** from the date they receive notice of an adverse benefit determination to submit an initial written appeal or complaint. If an appeal or complaint is not submitted within the timeframes outlined in this section, the member will lose the right to the appeal and complaint process.

10.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a voluntary second level appeal. If a member is not satisfied with the outcome of the first level appeal, and the dispute meets the specifications outlined in section 10.2.5, the member may request a second level appeal.

The timelines addressed in section 10.2 do not apply when the member does not reasonably cooperate or circumstances beyond the control of either party (Delta Dental or the member) makes it impossible to comply with the requirement. Whoever is unable to comply must give notice of the specific reason to the other party as soon as possible when the issue arises.

The member may review the claim file and submit evidence as part of the appeal process, and may appoint a representative to act on their behalf.

10.2.4 First Level Appeals

A first level appeal or complaint must be submitted in writing. If necessary, Customer Service can provide help with filing an appeal or complaint. Delta Dental will conduct an investigation by persons who were not involved in the initial determination.

When an investigation is finished, Delta Dental will send a written notice of the decision to the member, including the reason for the decision. Investigations will be completed and a notice will be sent within 30 calendar days. The notice on a decision regarding a utilization review issue will include the right to file a voluntary second level appeal.

10.2.5 Second Level Appeals

A member who disagrees with the decision on the first level appeal of a utilization review issue may ask for a review of the decision. The second level appeal is voluntary and must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal.

Investigations and responses to a second level appeal will be by the Board of Trustees, as the plan administrator and Health Trust Administrator who were not involved in the initial decisions, and will follow the same timelines as those for a first level appeal. The Health Trust Administrator will notify the member in writing of the decision, the reason for the decision, and if applicable, information on the right to file a lawsuit under ERISA Section 502(a).

If the member elects to request a second level appeal, any statute of limitation or timeline pertaining to the rights for further review, such as a lawsuit under ERISA Section 502(a), will be paused during the review process until a decision is made.

If a member chooses not to pursue the second level appeal, the Plan waives any right to assert that the member failed to exhaust its internal review process should the member elect to file a lawsuit in court under ERISA Section 502(a) following the first level appeal.

10.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.3.1 Coordination of Benefits (COB)

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

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, 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.

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

When another plan does not have a COB provision, that plan is primary. When another plan does have a COB provision, the first of the following rules that applies will govern:

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

is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g., a retired employee), the order of benefits between the two plans is reversed.

b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.) If another plan does not include this rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan is the primary plan.

c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married, then the following rules apply:
   i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
   ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
   iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
      A. custodial parent
      B. spouse or domestic partner of the custodial parent
      C. non-custodial parent
      D. spouse or domestic partner of the non-custodial parent

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.

e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's domestic partner's plans began on the same day, the birthday rule will apply.

f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers a member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

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

10.3.1.2 How COB Works

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

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

If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

10.3.1.3 COB and Plan Limits

If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

10.3.1.4 Definitions

For purposes of section 10.3.1, the following definitions apply:

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

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management 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

Plan does not include:

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

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

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

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

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.

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

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

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

10.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan.

The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to members the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed in full from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party or other source, no matter how the recovery is characterized.

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

10.3.2.1 Definitions

For purposes of section 10.3.2, the following definitions apply:

Benefits means any amount paid by the Plan or submitted to Delta Dental for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Recovery Funds means any amount recovered from a third party.

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member, regardless of how the claims, damages or recovery funds are characterized. (For example, a member who has received payment of dental/medical expenses from the Plan may file a third party claim, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover benefits as described in section 10.3.2.)

10.3.2.2 Subrogation

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

10.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its option, require a member and the member's attorney, if any, to protect its recovery rights. The following rules apply:

a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.

b. The Plan is entitled to receive the amount of benefits it has paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is true whether or not the third party admits liability or claims that the member is also at fault. In addition, 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 the Plan is subject to ERISA, the Plan is not responsible for and will not pay any fees or costs associated with the member pursuing a claim against a third party. The Plan is entitled to full reimbursement, without discount and without reduction for attorney fees and costs. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies under the Plan.

d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan, out of any recovery made by the member from the third party, including without limitation any and all amounts from the first dollars paid or payable to the member (including the member's legal representatives, estate or heirs, or any trust

established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

10.3.2.4 Additional Provisions

Members shall comply with the following and agree that the Plan may do one or more of the following, at its option:

a. The member shall cooperate with Delta Dental to protect the Plan's recovery rights, including by:
   i. Signing and delivering any documents Delta Dental reasonably requires to protect the Plan's rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 10.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider
   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing the Plan's third party recovery rights

b. The member and the member's representatives are obligated to notify Delta Dental in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party

c. By accepting payment of benefits by the Plan, the member agrees that the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 10.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.3.2.

f. Section 10.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member's representatives fails to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim. Delta Dental may notify dental/medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has dental/medical coverage under more than one plan or dental/medical insurance policy) is not considered a third party claim.

SECTION 11. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT & RELEASE NEEDED INFORMATION

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

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Delta Dental. Protected health information includes enrollment, claims, and medical and dental information. Such information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses members' information. Delta Dental, as the claims administrator, is required to follow these same practices. Members may contact the Group if they have additional questions about the privacy of their information beyond what is provided in the Notice of Privacy Practices.

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer is not binding on the Plan. The Plan shall pay amounts due under the Plan directly to the provider upon the member's written request.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan makes a payment for a member to which the member is 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 it would provide for a member even if the mistaken payment was not made on that member's behalf.

11.5 CORRECTION OF PAYMENTS

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

11.6 CONTRACT PROVISIONS

The agreement between Delta Dental and the Group including 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.

11.7 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.

11.8 LIMITATION OF LIABILITY

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

11.9 PROVIDER REIMBURSEMENTS

Providers contracting with Delta Dental to provide services to members agree to look only to the Plan for payment of the part of the expense that is covered by the Plan and may not bill the member in the event the Plan fails to pay the provider for whatever reason. The provider may bill the member for applicable cost sharing or non-covered expenses except as may be restricted in the provider contract.

11.10 INDEPENDENT CONTRACTOR DISCLAIMER

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

11.11 NO WAIVER

Any waiver of any provision of the Plan, or any performance under the Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If Delta Dental or the Plan delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

11.12 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.

11.13 GOVERNING LAW

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

11.14 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.

11.15 TIME LIMIT FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan or Delta Dental by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

SECTION 12. CONTINUATION OF DENTAL COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Group or participating employer to find out whether they qualify for this coverage. Subscribers and their dependents should read the following sections carefully.

12.1 COBRA CONTINUATION COVERAGE

12.1.1 Introduction

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

a. The Plan will offer no greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the notice, election or other requirements outlined below

For purposes of section 12.1, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

12.1.2 Qualifying Events

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

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

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

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

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

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the participating employer

c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a "child" under the Plan

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

12.1.3 Other Coverage

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

12.1.4 Notice and Election Requirements

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

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

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

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

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

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

12.1.5 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member

provides notice of electing coverage (this is the date the election notice is postmarked if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. A bill will not be sent for any payments due. The member is responsible for paying the applicable premiums when due; otherwise, continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

12.1.6 Length of Continuation Coverage

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

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

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

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

12.1.7 Extending the Length of COBRA Coverage

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

Disability. If any member is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period. Each family member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination
b. the date of the subscriber's termination of employment or reduction of hours

c. the date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours

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

If the Social Security Administration determines the member is no longer disabled, the disability extension ends. The member must notify the COBRA Administrator no more than 30 days after the Social Security Administration's determination that they are no longer disabled.

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

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

12.1.8 Special Enrollment & Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children or new spouses as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 8 and 9), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.1.9 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. any required premiums are not paid in full on time
b. a member becomes covered under another group dental plan
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA (However, if the qualifying event is the Group's or participating employer's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. the Group or participating employer ceases to provide any group dental plan for its employees
e. during a disability extension period (section 12.1.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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

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

12.2 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

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

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

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

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

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

12.3 FAMILY & MEDICAL LEAVE

Subscribers should check with the Group to find out if they qualify for this coverage.

If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to

work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.

c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

SECTION 13. ERISA DUTIES

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should check with the participating employer to determine if this section is applicable.

13.1 PLAN ADMINISTRATOR AS DEFINED UNDER ERISA

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

13.2 INFORMATION ABOUT THE PLAN AND BENEFITS

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

13.3 CONTINUATION OF GROUP DENTAL PLAN COVERAGE

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

13.4 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of 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.

13.5 ENFORCEMENT OF RIGHTS

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

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

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

13.6 ASSISTANCE WITH QUESTIONS

For questions about section 13 or a member's rights under ERISA, or for assistance obtaining documents from the Group, members should contact one of the following:

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

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

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

SECTION 14. DEFINITIONS

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have 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 15).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in Section 15).

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 a specific member's tooth that is made at a laboratory or dental office and cemented into the tooth.

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

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

Cost Sharing is the share of costs a member must pay when receiving a covered service, including deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network 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. The covered expense is a determination of what should be the market rate fee charged by any dentist in a given region. 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.

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 that are paid by a member before benefits are payable by the Plan.

Delta Dental means Delta Dental of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service. Delta Dental is the claims administrator of the Plan. Delta Dental processes claims and the group reimburses Delta Dental for any benefit issued.

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

a. are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan

b. are appropriate with regard to standards of good dental practice in the service area
c. have a good prognosis
d. are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately

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

Dentist means a licensed dentist operating within the scope of their license as required under law within the state of practice.

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

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

Eligible Employee, means any employee or former employee of the Group who has met the eligibility requirements to be enrolled on the Plan (see section 8.1).

Exclusion Period means a period of time during which specified treatments or services are excluded from coverage.

The **Group** is Health Care Cost Maintenance Corporation of Alaska dba The Pacific Health Coalition, the organization that has contracted with Delta Dental to provide claims and other administrative services. It also means the Plan Sponsor.

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

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 jawbone and supports a single crown, fixed bridge, or partial or full denture.

Implant Abutment is an attachment used to connect 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 means a subscriber, dependent of a subscriber or a person otherwise eligible for the Plan who has enrolled for coverage under the terms of the Plan.

Out-of-network refers to 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 performed every 6 months.

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

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

Plan Year means the 12-month period commencing on the original effective date and each 12-month period thereafter. See section 4 (Benefits and Limitations)

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 15).

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 amount reimbursable under the Plan. For in-network Delta Dental PPO dentists, this amount is the lesser of the covered expense, the fee in the PPO Fee Schedule or the dentist's billed charge. For participating 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 the covered expense or 100% of the provider's billed charge. A non-participating dentist has the right to bill the difference between the reimbursement amount and the actual charge. This difference will be the member's responsibility.

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

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

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.

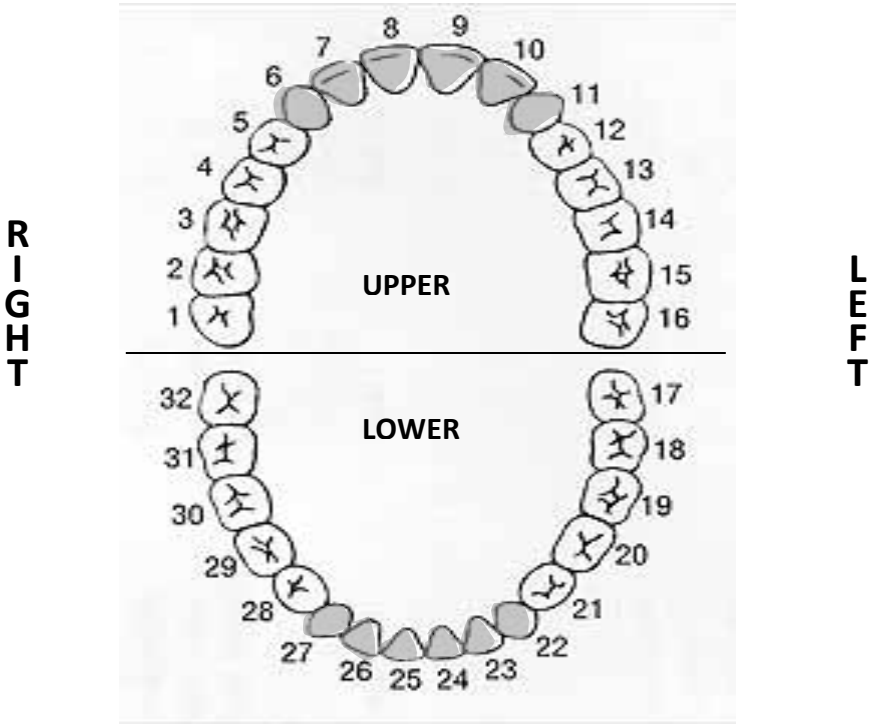
Subscriber means any employee or former employee who is enrolled in the Plan.

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

SECTION 15. TOOTH CHART

THE PERMANENT ARCH



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 16. EXAMPLE OF HOW THE PLAN PAYS

In this example, this Plan pays 80% of the reimbursement amount for in-network benefits and fpar

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							
$200	$180	$140	80%	$112	20%	None	$28
Delta Dental Premier Participating dentists (Out-of-network)							
$200	$180	$160	60%	$96	40%	None	$64
Nonparticipating dentists (Out-of-network)							
$200	$180	$180	60%	$108	40%	$20	$92

Nondiscrimination notice

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

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

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

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

888-217-2365 (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

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief 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.

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. 0569 (8/20)

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

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)

P.O. Box 40384
Portland, OR 97240