DELTA DENTAL®

2026

Alaska Group Dental Plan

Group name
Delta Dental PPO™, PF 1000, 100/90/50, 50
Effective Date: January 1, 2026
Group # 123456789

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SECTION 1. WELCOME TO DELTA DENTAL OF ALASKA

We are pleased your Group has chosen Delta Dental of Alaska (abbreviated as Delta Dental) as its dental plan. This handbook gives you important information about the Plan's benefits, limitations and procedures.

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

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

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

This plan provides pediatric dental coverage as required under the Affordable Care Act.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

Dental Customer Service Department
Toll-free 888-374-8906
En español 877-299-9063

Appeals Department
P.O. Box 40384
Portland, OR 97240
Fax 503-412-4003

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBER ID CARD

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

2.3 NETWORK

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

Dental network
Delta Dental PPO™

2.4 OTHER RESOURCES

You can find other general information about the Plan in Section 9.

SECTION 3. USING THE PLAN

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

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

3.1 NETWORK INFORMATION

Delta Dental plans give you 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. It is easy to use and cost effective. Covered dental expenses are paid at a higher rate when you use an in-network Delta Dental PPO™ dentist, and all of the paperwork takes place between the dentist's office and us. If you are outside Alaska, Delta Dental Plans Association provides offices and/or contacts in every state. Choose an in-network dentist from the Delta Dental PPO Directory by using Find Care on your Member Dashboard. Subscribers who move outside of the service area must contact us for help.

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

3.1.1 In-Network Delta Dental Dentists

Covered expenses are paid at the in-network, PPO rate when you use an in-network Delta Dental PPO dentist. Payment to in-network Delta Dental PPO dentists is the lesser of the covered expense, the PPO Fee Schedule amount and the dentist's actual billed charge. The dentist may not charge you for the difference between the PPO fee schedule amount and the billed charge for covered services.

3.1.2 Out-of-Network Dentists

Payment to an out-of-network dentist participating in the Delta Dental Premier network is at the out-of-network rate and is based on the covered expense, the dentist's filed or contracted fee with Delta Dental, or fees actually charged, whichever is less. The dentist may not charge you for the difference between the filed fee and the billed charge.

Payment to an out-of-network dentist that is not participating in a Delta Dental network is at the out-of-network coinsurance and is limited to the reimbursement amount (as defined in Section 10). If you do not have reasonable access (within 50 miles) to an in-network dentist, we will pay for services from an out-of-network dentist in Alaska at the in-network benefit level. The

reimbursement amount is the amount for out-of-network dentists. You may have to pay the difference between the reimbursement amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

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

SECTION 4. BENEFITS AND LIMITATIONS

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

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

Covered dental services are 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 6 for exclusions.

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

a. Have an after-hours dental issue
b. Have a dental emergency and you do not have a regular dentist
c. Want a dental consultation without leaving home
d. Are traveling and need dental assistance

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

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

Out-of-pocket maximum for members under age 19:
$450 for one member, $900 for 2 or more members per year.
All covered services count toward your out-of-pocket maximum.

Annual maximum plan payment limit for members age 19 and over:
$1,000 per member per year, or portion thereof
All covered services apply to the annual maximum plan payment limit except:
a. Class I (other than cone beam x-rays)
You will have to pay any charges after the annual maximum plan payment limit is reached.

4.1 CLASS I: DIAGNOSTIC AND PREVENTIVE SERVICES

	In-network (Delta Dental PPO dentists)	**Out-of-network** (all other dental providers)
Under age 19	Covered services paid at 100% of the reimbursement amount	Covered services paid at 80% of the reimbursement amount
Age 19 and over	Covered services paid at 100% of the reimbursement amount	Covered services paid at 90% of the reimbursement amount

4.1.1 Diagnostic

a. Diagnostic Services:

i. Exam
ii. Consultations for covered dental procedures
iii. Intra-oral x-rays to assist in determining required dental treatment
iv. Interpretation of diagnostic image for members under age 19

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive exams (including problem focused comprehensive exams) or consultations are covered twice per calendar year
ii. Limited exams or re-evaluations are covered twice per year
iii. Complete series x-rays or a panoramic film is covered once in any 5-year period
iv. Supplementary bitewing x-rays are covered once in any 6-month period under age 19 and once every 12 months if you are age 19 and over
v. Separate charges to review a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
vi. Only these x-rays are covered: complete series or panoramic, cone beam, cephalometric, periapical, occlusal and bitewing
vii. A separate fee to interpret a diagnostic image is only covered for members under age 19 and when it is by a different dentist than the one who took the image

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 calendar year.* Additional periodontal maintenance is covered if you have periodontal disease, up to a total of 2 additional periodontal maintenances per year.
ii. Adult prophylaxis is only covered if you are age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered twice per calendar year if you are under age 19. If you are age 19 and over, topical application of fluoride is covered once in

any 12-month period if you have a recent history of periodontal surgery or a high risk of decay because of medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene is not a medical disease).

iv. Interim caries arresting medicament application is covered twice per tooth per year
v. Sealants are only covered on the unrestored, occlusal surfaces of permanent molars. Benefits are limited to one sealant per tooth during any 3-year period if you are under age 19 and one sealant per tooth in any 5-year period if you are age 19 and over.
vi. Space maintainers are covered once per space. Space maintainers for primary anterior teeth or missing permanent teeth, or if you are age 19 and over are not covered.

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

4.2 CLASS II: BASIC SERVICES

	In-network (Delta Dental PPO dentists)	**Out-of-network** (all other dental providers)
Under age 19	Covered services paid at 100% of the reimbursement amount	Covered services paid at 50% of the reimbursement amount
Age 19 and over	Covered services paid at 90% of the reimbursement amount	Covered services paid at 70% of the reimbursement amount

4.2.1 Restorative

a. Restorative Services:

i. Amalgam and composite fillings to treat decay
ii. Stainless steel crowns
iii. Prefabricated porcelain/ceramic crown for a primary tooth for members under age 19.

b. Restorative Limitations:

i. Restorations are not covered within 2 months of interim caries arresting medicament application if you are age 19 or over
ii. Inlays are considered an optional service. We will pay an alternate benefit of a composite filling.
iii. Crown buildups are included in the crown restoration cost. A buildup is covered only if necessary for tooth retention.
iv. Prefabricated and indirectly fabricated post and core in addition to a crown are only covered if you are age 19 or over, and only when less than half of the coronal (above the gum) tooth structure remains
v. Replacement of a stainless steel crown by the same dentist within 2 years of placement is not covered. The replacement is included in the charge for the original crown.
vi. A prefabricated porcelain/ceramic crown for a primary tooth is covered once in any 5-year period for members under age 19

vii. See section 4.3.1 for additional limitations when teeth are restored with crowns or other cast restorations

4.2.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical)
ii. Other minor surgical procedures

b. Oral Surgery Limitations:

i. Surgery on larger lesions or malignant lesions is not considered minor surgery
ii. A separate charge for post-operative care done within 30 days after an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
iii. Brush biopsy is covered once in any 6-month period. Benefits are limited to the sample collection. Pathology (lab) services are not covered.

4.2.3 Endodontic

a. Endodontic Services:

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

b. Endodontic Limitations:

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

4.2.4 Periodontic

a. Periodontic Services:

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants
ii. Collection and application of autologous blood concentrate product for members under age 19

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once per quadrant in any 2-year period
ii. Periodontal maintenance is covered under Class I, Preventive
iii. A separate charge for post-operative care done within 3 months after periodontal surgery is not covered
iv. Osseous surgery is limited to 2 quadrants per visit if you are age 19 or over
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 if you are age 19 or over
vii. Full mouth debridement is limited to once in a 2-year period. If you are age 19 and over, it is not covered if you have had a cleaning (prophylaxis, periodontal maintenance) within the last 2 years
viii. Collection and application of autologous blood concentrate product is limited to once in any 36-month period, and must be dentally necessary. You must be under age 19.

4.2.5 Anesthesia

a. Anesthesia Services:
i. General anesthesia or IV sedation

b. Anesthesia Limitations:
General anesthesia or IV sedation is covered only:
i. In conjunction with a covered surgical procedure done in a dental office
ii. When necessary due to concurrent medical conditions

4.3 CLASS III: MAJOR SERVICES

	In-network (Delta Dental PPO dentists)	**Out-of-network** (all other dental providers)
Under age 19	Covered services paid at 100% of the reimbursement amount	Covered services paid at 50% of the reimbursement amount
Age 19 and over	Covered services paid at 50% of the reimbursement amount	Covered services paid at 50% of the reimbursement amount

4.3.1 Restorative

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

b. Restorative Limitations:
i. Cast restorations (including pontics) are covered once in any 5-year period if you are under age 19 and once in any 7-year period if you are age 19 and over 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. We will pay for a gold restoration, and you will have to pay the difference.
iii. If your tooth can be restored with a material such as composite, but you or your dentist choose another type of restoration, the covered expense is limited to the cost of composite. Crowns are only covered if the tooth cannot be restored by a routine filling.
iv. Restorations are not covered within 2 months of interim caries arresting medicament application

v. A separate, additional charge to repair a restoration done within 2 years of the original restoration is not covered if you are age 19 or over
vi. Re-cement or re-bond of a crown, inlay, onlay or veneer by the same dentist is limited to once per lifetime if you are age 19 or older

4.3.2 Prosthodontic

a. Prosthodontic Services:

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

b. Prosthodontic Limitations:

i. A bridge or a full or partial denture is covered once in a 5-year period under age 19 and once in a 7-year period if you are age 19 and over. Bridges and dentures are only covered if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last 5 years if you are under age 19, and in the last 7 years if you are age 19 and over.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount is limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered
iii. Partial dentures: A temporary (interim) partial denture is only covered when placed within 2 months of the extraction of an anterior tooth or to replace missing anterior permanent teeth for members age 16 or under. If a specialized or precision device is used, covered expense is limited to the cost of a standard cast partial denture. Cast restorations for partial denture retainer teeth are not covered unless the tooth requires a cast restoration because it is decayed or broken.
iv. Denture adjustments, repairs and relines: A separate, additional charge for denture adjustments, repairs and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
v. Tissue conditioning is covered no more than twice per denture in a 3-year period
vi. Surgical placement and removal of implants are covered when dentally necessary, and at least 5 years after the last cast restoration. Implant maintenance is limited to once every 3 years, except when dentally necessary. Scaling and debridement of an implant is covered once in a 2-year period. The Plan also covers these services:
    A. The final crown and abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period under age 19, and once per tooth or tooth space over the lifetime of the implant if you are age 19 and over
    B. An alternate benefit per arch of a full or partial denture for the final prosthetic when the implant is placed to support a prosthetic device
    C. The final implant-supported bridge retainer and implant abutment or pontic. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth

D. You are not eligible for these benefits or alternate benefits if we paid a cast restoration or prosthodontic benefit, including a pontic, for that tooth, implant or tooth space for members under age 19 or within the previous 7 years if you are ages 19 and older

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

viii. Repair of an implant abutment supported prosthesis is limited to once in a 2-year period

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

4.3.3 Other

a. Other Services

i. Night guard (occlusal guard) for ages 13 and older

ii. Athletic mouthguard

b. Other Limitations

i. A night guard (occlusal guard) is covered once per year age 13 to 19. It is covered once every 5 years at 100% up to a $200 maximum if you are age 19 and over. There is no deductible. Over-the-counter occlusal guards are not covered.

ii. Repair or reline of an occlusal guard is covered once in any 12-month period. One occlusal guard adjustment is covered 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 24-month period if you are age 16 and over. Over-the-counter athletic mouthguards are not covered.

4.3.4 Orthodontia

a. Orthodontia Services:

i. For members under age 19, orthodontia, including placement of a device to facilitate eruption of an impacted tooth, is covered when medically necessary as defined below. There is no dollar limit.

b. Orthodontia Limitations:

i. Covered only when done in a dental office. Self-administered orthodontics are not covered

ii. Medically necessary orthodontic services are diagnosis and treatment to repair disabling malocclusion or cleft palate, or severe craniofacial defects that impact speech, swallowing or chewing

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

iv. A separate charge to repair or replace an appliance furnished under the Plan is not covered

4.4 GENERAL LIMITATION – OPTIONAL SERVICES

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

4.5 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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

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

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

SECTION 5. ORAL HEALTH, TOTAL HEALTH PROGRAM

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

5.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

This benefit is for the cleaning only. Coverage for routine exams and other services is subject to the frequency limitations described in Section 4.

5.1.1 Diabetes

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

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

5.1.2 Pregnancy

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

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

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. 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, contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on your Member Dashboard. If you have diabetes, you must include proof of diagnosis.

SECTION 6. EXCLUSIONS

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

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

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

Behavior Management
(except as stated in section 4.5)

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

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

Congenital or Developmental Malformations
If you are age 19 and over. Includes treating cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth)

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

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

Duplication and Interpretation of X-rays or Records
Except interpretation of diagnostic images as described in section 4.1.1

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

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

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

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

Inmates
Services and supplies you get while you are 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, except as described in section 4.5 for IDD

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

Maxillofacial Prosthetics
Except surgical stents as stated in section 4.3.2

Missed Appointment Charges

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

Orthodontia
Except medically necessary orthodontia for members under age 19

Over the Counter
Including over the counter occlusal guards (night guards) and athletic mouth guards

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

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

Rebuilding or Maintaining Chewing Surfaces; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except an occlusal guard (night guard) or athletic mouthguards as provided in section 4.3. Excluded services include increasing vertical dimension, equilibration and periodontal splinting.

Self-Treatment
Services you provide to yourself

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

Services on Tongue, Lip or Cheek

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

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

Taxes

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

Third Party Liability Claims
Services and supplies to treat illness or injury that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 7.3.2)

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ) and cone beam imaging related to TMJ

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

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

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services and supplies that are:

a. Not dentally necessary to treat or prevent a dental injury or disease otherwise covered under the Plan
b. Inappropriate with regard to standards of good dental practice
c. Have a poor prognosis

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

Treatment of Closed Fractures

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 SUBMISSION AND PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim no more than 12 months after the date of service
b. We will not pay any claims we do not receive on time. The only exception is absence of legal capacity

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

Usually, you can show your Delta Dental ID card to the dental office and they will bill us for you. We will pay the dentist and send a copy of our payment record to you. The dentist will then bill you for any charges that were not covered. If you choose a non-participating dentist or dental provider, claim forms are available on the Member Dashboard.

7.1.1 Explanation of Benefits (EOB)

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

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 7.1.

7.1.2 Claim Inquiries

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

7.1.3 Time Frames for Processing Claims

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

a. If we do not need any additional information, we will pay or deny the claim. We will send you an EOB showing the payment or explaining any denial.
b. If we need more information, we will send you a notice describing the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information or 30 days of the day we first received the claim.

If we do not finish processing your claim on time, we will pay interest at the rate of 15% annually until we have finished processing the claim. We must receive all information we need to process your claim within the claim submission period explained in section 7.1.

7.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

7.2.1 Time Limit for Submitting Appeals and Complaints

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

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

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see "Filing an Appeal" in Section 11). Describe what happened and what outcome you are hoping for. Include dental records or other documentation that will help us investigate your appeal.

You may request an extension to these timeframes. Your request must be in writing and include at least one reason that you need the extension, with a fair and reasonable basis for us to allow it.

7.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and an optional second level appeal. If you are not satisfied with the result of the first level appeal, and the dispute is about a utilization review decision, you may ask for a second level appeal. If your dispute meets the criteria, you may ask for external review by an independent review organization (section 7.2.3).

You may review the claim file and submit evidence to support your appeal. You may choose a person (representative) to act on your behalf. You must sign an authorization to disclose protected health information (PHI) allowing your representative to act for you. You may find this form on deltadentalak.com. Contact Customer Service for help assigning your representative.

A Delta Dental employee or agent who holds the same or similar specialty as the dental provider who would typically manage the case being reviewed will make the decision about your appeal.

How First and Second Level Appeals Work

a. Submit your appeal or complaint in writing, on time. If you need help, ask Customer Service.
b. We will send you a letter no more than 3 business days after we receive your appeal so you know we got it. We will include notice of the appeal provisions.
c. Someone who was not involved in the original decision will investigate your appeal.
d. We will send the decision to you within 30 days. The notice will include information about any more appeal or review rights you have, including any right to sue.

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

You do not have to file the optional second level appeal to complete the Delta Dental internal review process. Once the first level appeal process is complete, the required internal review process has been exhausted and the member can sue under ERISA Section 502(a).

Special Circumstances
The timelines for reviewing your appeal do not apply if:

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

You must go through the first level appeal before you can sue under ERISA Section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights, unless we have not met the internal timeline for review or the federal requirements for providing related information and notices.

7.2.3 External Review

If your appeal meets the criteria below, you may ask to have it reviewed by an independent review organization (IRO) appointed by the Alaska Division of Insurance.

a. You must sign a HIPAA release waiver allowing the IRO access to your dental records
b. The request for external review must be in writing to the director of the Alaska Division of Insurance no more than 180 days after you receive the adverse benefit determination. For expedited review, your request may be made by phone. You may submit additional information to the IRO within 5 business days, or 24 hours for an expedited review. You may request an extension to the 180-day limit. The request must be in writing and include at least one justification, with a fair and reasonable basis for allowing the extension.
c. You must have completed the appeal process described in section 7.2. We will send an appeal directly to external review if we both agree to skip this requirement.
d. You must give the IRO complete and accurate information in a timely manner.

Only certain types of appeals are eligible for external review. The dispute must relate to:

a. An adverse benefit determination based on a utilization review decision
b. Rescission of coverage (but not other disputes about eligibility)
c. Cases in which we have not met the internal timeline for review or the state or federal requirements for providing related information and notices

If your request is incomplete or ineligible for external review, we will send you a written notice no more than 6 business days after we receive your external review request from the Alaska Division of Insurance. Otherwise, the IRO will send you a written notice of the final external review decision within 45 days of its receipt of the request.

The decision of the IRO is binding except to the extent other remedies are available to you under state or federal law, such as filing a civil suit in superior court.

7.2.4 Complaints

Submit your complaint in writing within 180 days from the date of the claim. We will review complaints about:

a. Availability, delivery or quality of a dental service

b. Claims payment, handling or reimbursement for dental services that is not appealing an adverse benefit determination
c. The contractual relationship between us

We will finish reviewing your complaint within 30 days. If we need more time, we will notify you about the delay. We will have 15 more days to make a decision.

7.2.5 Additional Member Rights

If you need other help with your appeal rights, contact:

a. Employee Benefits Security Administration
   Phone: 866-444-3272
b. Alaska Division of Insurance:
   Phone: 800-467-8725
   Fax: 907-269-7910
   Mail: Division of Insurance, Consumer Services Section
   550 West 7th Ave., Ste. 1560
   Anchorage, AK 99501
   email: insurance@alaska.gov
   Internet: www.commerce.alaska.gov/web/ins/Consumers/ConsumerComplaint.aspx

7.2.6 Definitions

For purposes of section 7.2, the following definitions apply:

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

a. Eligibility to participate in the Plan
b. Utilization review (described below)
c. Limitations or exclusions described in Section 4 or Section 6, including a decision that an item or service is experimental or investigational or not dentally necessary

Appeal is a request by you or your representative for us to review an adverse benefit determination.

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

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

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

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

7.2.7 Member Disclosures

If I am not satisfied with the plan, how can I file an appeal or complaint?

You can file an appeal or complaint by writing a letter to Delta Dental. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Dental records from the provider, if applicable
g. Reason for the appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 7.2.

7.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

7.3.1 Coordination of Benefits (COB)

Coordination of Benefits applies when you have dental coverage under more than one plan.

If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The Plan follows order of benefit determination rules based on NAIC model rules. These rules decide which plan is primary and pays a claim for benefits first.

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

7.3.1.1 When This Plan Pays First

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

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

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

7.3.1.2 How COB Works

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

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

a. We will calculate the benefits we would have paid if you did not have any other dental coverage. We will apply that amount to any allowable expense that the primary plan did not pay
b. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
c. If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will count against any benefit limit in those plan provisions

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

Any plan that does not have a COB provision is always primary.

7.3.1.3 Definitions

For purposes of Section 7, the following definitions apply:

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

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

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

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

Plan does not include:

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

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

These are not allowable expenses:

a. Any expense that is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you
c. Services in excess of a plan's visit or dollar paid limit when the limit has been met

7.3.2 Third Party Liability

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

The Plan does not cover benefits when someone else (a third party) is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and agreement that we are entitled to be reimbursed in full for any benefits we paid that are or may be recoverable from a third party or other source, no matter how the recovery is characterized.

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

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

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

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

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 7.3.2

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

f. Section 7.3.2 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Delta Dental

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

SECTION 8. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

8.1 SUBSCRIBER

You must give the Group a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Your coverage begins on the date specified in the policy. This will be on your enrollment date or after a waiting period.

To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You must tell us and the Group if your address changes.

8.2 DEPENDENTS

A subscriber's legal spouse is eligible for coverage. If a subscriber marries, the spouse and their children can enroll as of the date of the marriage. Coverage 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.

Except, if the subscriber and spouse are legally separated, the spouse is not eligible unless the spouse meets the requirements to enroll as an employee.

A subscriber's children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26.

In this Plan, eligible children are:

a. The biological or adopted child of the subscriber or the subscriber's eligible spouse
b. Children placed for adoption with the subscriber
c. Your newborn child
d. Children related to the subscriber and the subscriber is their legal guardian

Your newborn child is eligible from birth and coverage begins that day. A subscriber's adopted child, or child placed for adoption, is eligible on the date of placement. Their coverage begins on the date of adoption or placement. Court ordered coverage begins on the first day of the month after the date the Group determines that the order qualifies as a QMCSO, and that the child is eligible to enroll in the Plan. You must provide proof of legal guardianship to cover the subscriber's grandchild after the first 31 days from birth if the grandchild's parent is not an enrolled dependent under the Plan. See section 8.2.1 to add your new child.

Children with Disabilities
A subscriber's child who has a disability that makes them physically or mentally unable to support themself at even a sedentary level may be eligible for coverage even when they are over 26 years old. To be eligible, the child must be:

a. Unmarried and mainly dependent on the subscriber for support
b. Have had continuous dental coverage
c. The disability must have started before the child's 26th birthday

We must receive this information before the child's 26th birthday:

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

We recommend sending this information to us at least 45 days before their 26th birthday so there is no gap in coverage. Social Security Disability status does not guarantee your child will be eligible for over-age coverage. Eligibility is determined based on their medical condition, using commonly accepted guidelines. Eligibility will be reviewed from time to time unless the disability is permanent.

If the child is eligible for coverage under the medical plan, they are also eligible under this dental plan. If the medical coverage is not through Moda Health, you must send us the medical carrier's determination that the child is eligible for over-age coverage at least 45 days before the child's 26th birthday to avoid a break in coverage.

8.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered (coverage for a new child will end 31 days after birth or adoption).

To add a new dependent to your coverage, submit:

a. Complete and signed application
b. Documentation. This may be a marriage certificate, birth certificate, or guardianship, adoption or placement for adoption paperwork

You must apply within 31 days of the new dependent becoming eligible. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums.

8.3 OPEN ENROLLMENT

If you are not enrolled within 31 days of first becoming eligible, you must wait for the next open enrollment period to enroll unless:

a. You qualify for special enrollment as described in section 8.4
b. A court has ordered you to provide coverage for a spouse or minor child under a subscriber's dental plan. You must enroll no more than 30 days after the court order is issued

Open enrollment occurs once a year at renewal. If you enroll during open enrollment, coverage begins on the date the Plan renews.

8.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled in 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.

8.4.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other dental coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

a. You stated in writing that you already had dental coverage when this Plan was first offered to you
b. You ask to enroll is requested no more than 31 days after your prior coverage ended
c. You have a qualifying event. These are:
    i. Your other coverage ended because you were no longer eligible. Examples of when this happens include:
        A. loss of dependent status per plan terms, including divorce or legal separation
        B. end of employment or not working enough hours
        C. reaching the lifetime maximum on all benefits
        D. the plan stops offering coverage to a specific group of similarly situated persons
        E. moving out of an HMO service area and the pan does not have another option
        F. the benefit package option is canceled, and no substitute option is offered
    ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll.
    iii. You exhausted your COBRA continuation

8.4.2 Payment Changes

You may have special enrollment rights when there are changes to how your premiums are paid:

a. Employer contributions toward your other active coverage (not COBRA coverage) end. You must ask for special enrollment no more than 31 days after the contributions end
b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the premium contribution or subsidy change.

8.4.3 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, birth, adoption or placement for adoption). You can enroll along with your new dependent. See section 8.2.1.

8.4.4 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in the Plan.

8.5 WHEN COVERAGE ENDS

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

8.5.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends. This may happen because the Group chooses to end the Plan, or we may end the policy for fraud or intentional misrepresentation of material fact by the Group or if the Group does not follow the requirements of the policy.

8.5.2 Subscriber Ends Coverage

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.

8.5.3 Death

If the subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage for up to 3 years if you meet the requirements for continuation of coverage (see Section 9). The Group must tell us that your coverage is continued, and include your premiums with their regular monthly payment.

8.5.4 Termination, Layoff or Reduction in Hours of Employment

When the subscriber's employment ends, coverage ends on the last day of that month unless you choose to continue coverage (see Section 9).

If you are laid off or your work hours are reduced, coverage ends on the last day of the month you were eligible. You can restart your coverage as if it had never ended if you are back at work and working the required hours within 6 months.

Coverage will restart on the date you meet the eligibility requirements.

a. You will not have to re-serve a waiting period
b. The Group must notify us that you have been rehired following a layoff or that your hours have been increased
c. Your premiums must be paid

8.5.5 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 the marriage is legally ended (divorce, dissolution, annulment, legal separation, etc.),
b. Coverage ends for an enrolled child on the last day of the month in which
    i. the child reaches age 26. Coverage may end earlier for a grandchild, when the grandchild's parent is no longer a covered dependent of the subscriber
    ii. stepchild relationship ends due to divorce
    iii. legal guardianship ends

You must tell us when a marriage or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends (see Section 9).

8.5.6 Rescission

Recission means cancelling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group. This includes leaving out or not telling us information. Examples of fraud and material misrepresentation include but is not limited to:

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

We have the right to keep any premiums paid as liquidated damages. You and/or the Group will have to repay benefits that have been paid. If we rescind your coverage, we may, to the extent permitted by law, not allow you to enroll in any Delta Dental policy or contract or the contract of any affiliates in the future.

8.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including, but not limited to, member birth certificates, adoption paperwork, marriage certificates and any other evidence necessary to document your eligibility for the Plan.

SECTION 9. CONTINUATION OF DENTAL COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

9.1 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g., divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA

You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked if mailed, or the date the COBRA Administrator receives it, if hand delivered). The premium rate may include a 2% add-on to cover administrative expenses. All other payments are due on the 1st day of the month. You will not receive a bill for any payments due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of the subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period.

You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 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 you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premium. Your disability extension ends if you are no longer considered disabled.

If you are a spouses or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These events are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

When COBRA Ends. COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group dental plan to its employees. COBRA will also end if:

a. You become covered under another group dental plan
b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**
Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

9.2 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If a subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

9.3 FAMILY & MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will restart as if there had been no break in coverage.

SECTION 10. DEFINITIONS

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

Amalgam is a silver colored material used in restoring teeth.

Anterior refers to teeth at the front of the mouth (tooth chart in Section 12).

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

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

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

Calendar Year is a period beginning January 1st and ending December 31st.

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

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

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

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

Covered Expense is the Premier Fee Schedule amount. If the database does not contain a fee for a particular procedure in a particular region, the fee is based on the covered expense of a comparable service.

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

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

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

Delta Dental means Delta Dental of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service, a not-for-profit health insurer licensed in Alaska that contracts with the Group to provide dental insurance to you. Where this book refers to “we”, “us” or “our” it is referring to Delta Dental or its employees.

Dentally Necessary means services that:

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

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

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

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

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

Effective Date is the date coverage actually begins. For new policyholders, this is the first day of the month after we receive your application, unless another date is selected. For new dependents, it is the date of birth for a newborn child, the date of the adoption decree for an adopted child and the date of placement for a child placed for adoption. For new spouses, or if you qualify due to loss of creditable dental coverage, it is the first day of the month after the qualifying event.

Eligible Employee is an employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 8.1).

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

The **Group** is the organization whose employees are covered by the Plan.

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

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

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

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 with the Delta Dental PPO network to provide dental care to you.

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

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

Non-participating Dentist or Dental Provider is a licensed dental provider who has not contracted to be part of the Delta Dental PPO network or the Delta Dental Premier network. When you use one of these providers, your covered dental expenses are paid at the out-of-network rate shown in Section 4.

Out-of-network refers to licensed dental providers or services provided by licensed dental providers who are not contracted with the Delta Dental PPO network. When you use an out-of-network provider, your covered dental expenses are paid at the out-of-network rate shown in Section 4. Delta Dental Premier dentists are out-of-network.

Participating Delta Dental Premier Dentist is a licensed dentist who has agreed to provide services in the Premier network in accordance with Delta Dental's terms and conditions and has satisfied Delta Dental that is they are complying with such terms and conditions. If you use a Premier dentist, your covered dental expenses are paid at the out-of-network rate shown in Section 4.

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

Periodontal Maintenance is a periodontal procedure for members who have previously been treated for periodontal disease. This is a more comprehensive service than a regular cleaning (prophylaxis) where surfaces below the gum line are also cleaned.

The **Plan** is the dental benefit plan sponsored by the Group and insured under the terms of the policy between the Group and Delta Dental.

Policy is the agreement between the Group and Delta Dental for insuring the dental benefit plan sponsored by the Group. This handbook is a part of the policy.

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

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

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

Prophylaxis is cleaning and polishing of all teeth.

Reimbursement Amount is the maximum amount the Plan will reimburse providers. For a Delta Dental PPO dentist, this amount is the lesser of the covered expense, the fee in the PPO fee schedule or the dentist's billed charge. For Delta Dental Premier dentists, this amount is the lesser of the covered expense, the provider's accepted filed fee with Delta Dental or the dentist's billed charge. For non-participating dentists, this amount is the lesser of 75% of the covered expense or 100% of the provider's billed charge. When you use a non-participating dentist, you will have to pay the difference between the reimbursement amount and the actual charge.

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

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

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

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

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

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

Waiting Period is the period that must pass before you are eligible to enroll for benefits under the terms of the Plan.

SECTION 11. GENERAL PROVISIONS & LEGAL NOTICES

11.1 MISCELLANEOUS PROVISIONS

Contract Provisions
The policy between Delta Dental and the Group and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the policy plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how we use your PHI. Follow the Privacy Center link on the Delta Dental website for a copy of the notice, or call 855-425-4192.

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

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

Correction of Payments or Recovery of Benefits Paid by Mistake
If Delta Dental mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, we have the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf. We will give you or the provider 30 days written notice before recovering a payment. We will not do this more than 1 year from the date we made the original payment.

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

Warranties
All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by the

Group or the member, a copy of which has been given to the Group or member or member's beneficiary.

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

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

Responsibility for Quality of Dental Care
You always have the right to choose your dental provider. We are not responsible for the quality of your dental care. Your dentists act as independent contractors. We cannot control the detail, manner or methods by which a participating dentist provides care. We cannot be held liable for the negligence of any dentist providing services to you.

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

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

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

Time Limit for Filing a Lawsuit
Any legal action arising out of, or related to, the Plan and filed against 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 7.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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

notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

Filing an Appeal
You can file an appeal or complaint by writing a letter to Delta Dental. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Dental records from the provider, if applicable
g. Reason for the appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 7.2.

11.2 ERISA DUTIES

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

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

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

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA.

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of the members. No one, including

the employer or any other person, may fire or discriminate against a subscriber in any way to prevent the subscriber from obtaining a benefit or exercising rights under ERISA.

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you ask the Group for a copy of plan documents or the latest annual report and do not receive it within 30 days, you may file suit in federal court. The court may require the Group to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Group's control. If a claim for benefits is denied or no action is taken, you may file suit in state or federal court after you have exhausted the Plan's appeal process (see section 7.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

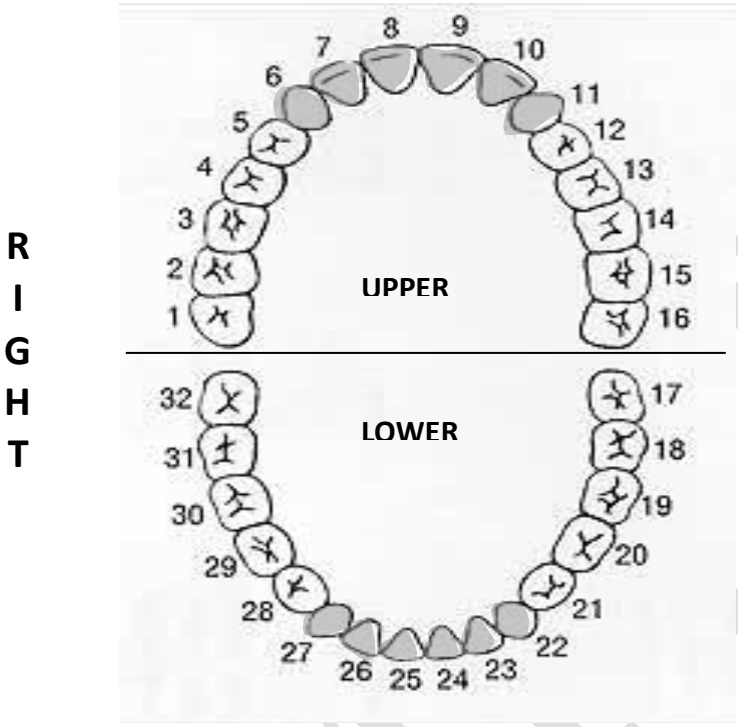
Assistance with Questions
For questions about this section or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

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

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

SECTION 12. 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 13. EXAMPLE OF HOW THE PLAN PAYS

In this example, the Plan pays 80% of the reimbursement amount for in-network benefits and 60% of the reimbursement for out-of-network benefits.

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, religion, color, national origin, age, disability, gender identity, sex or sexual orientation.

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

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

If you need any of the above, call:

888-217-2365 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

DeltaDentalAK.com | DeltaDentalOR.com

2688-NDS-DD (06/23)

DELTA DENTAL®

Delta Dental of Oregon & Alaska

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-605-3229 (TTY: 711))번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-605-3229 (TTY: 711) або зверніться до свого постачальника».

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

ຊາບໄວ້: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ

ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - (1-877-605-3229 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങൾ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة".

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.

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