

2023 Delta Dental Plan Benefit Summary



Delta Dental of Oregon & Alaska

ASEA/AFSCME Local 52 Health Benefits Trust

Group # 10019391

	PPO provider	Premier provider	Out-of-network non-participating provider
Annual Maximum Benefit**			
Per member		\$2,000	
Deductible			
Per member		\$25	
Per family		\$75	
Class 1*			
Periodic examinations / x-rays	100%	100%	100%
Prophylaxis (cleanings) / periodontal maintenance	100%	100%	100%
Sealants	100%	100%	100%
Space maintainers	100%	100%	100%
Topical application of fluoride	100%	100%	100%
Class 2			
Restorative fillings	85%	85%	85%
Oral surgery (extractions & certain minor surgical procedures)	85%	85%	85%
Endodontics (treatment of teeth with diseased or damaged nerves)	85%	85%	85%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	85%	85%	85%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive services.

** Preventative care does not accumulate to the annual max.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.DeltaDentalAK.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:

Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist, Non PPO:

Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:

Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.



Delta Dental of Oregon & Alaska

For more information, please call Customer Service at 888-374-8906 or visit www.deltadentalak.com/asea

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Alaska will pay the applicable percentage of the reimbursement amount for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations are covered twice per plan year. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice per plan year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. 2 additional cleaning per plan year available to members with diabetes. 1 additional cleaning available to pregnant members in 3rd trimester. Topical application of fluoride is covered for members and dependents. Sealants are covered for members and dependents on unrestored occlusal surfaces of permanent molars.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam or composite fillings are covered for all teeth. A separate charge for nitrous oxide, general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. Implant maintenance is covered once every 3 years.
- **Restorative** Crowns, inlays and onlays are covered once every 5 years per tooth when a tooth cannot be restored by a routine filling.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a five (5) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last five (5) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal guard** (night guard) is covered once per year between ages 13 and 19 and once every 5 years maximum for ages 19 and over. Over-the-counter occlusal guards are not covered.
- **Athletic mouthguard** covered once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.
- Prosthetic services are paid on the seat date.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia or any other euphoric drugs (except nitrous oxide, which is covered).
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

This is a summary of the dental plan benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control. Dental plans in Alaska provided by Delta Dental of Alaska. Delta Dental is a trademark of Delta Dental Plans Association.



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Delta Dental of Oregon & Alaska

Delta Dental Adult & Child Ortho 1500

Lifetime maximum	\$1,500
	What members pay
Members age 19+	50%
Members under age 19	50%

Eligible Employees and their covered dependents

How to use this dental plan

When you visit your dental provider, tell them you are a Delta Dental member.

Pre-determination

Your dental office can submit a pre-treatment plan to Delta Dental of Alaska on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

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AC1500

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