2025 Delta Dental Plan Benefit Summary
Daimler Trucks North America (UAW) Retirees

DELTA DENTAL
Delta Dental of Oregon & Alaska

Delta Dental PPO and Premier Network

Annual Maximum Benefit	
Per member	$1,500
Deductible	
Per member	$0
Class 1	
Periodic examinations / X-rays	100%
Prophylaxis (cleanings) / periodontal maintenance	100%
Sealants	100%
Space maintainers	100%
Topical application of fluoride	100%
Class 2	
Restorative fillings	80%
Oral surgery (extractions & certain minor surgical procedures)	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%
Class 3	
Implants	80%
Crowns and other cast restorations	80%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	80%
Orthodontia	
Adults and eligible dependents	80% up to a lifetime maximum of $1,500

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

How to use this dental plan

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

When the member visits:

Preferred Dentist (PPO):

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:

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:

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Dependent Eligibility:

Dependent eligibility is defined as per your collective bargaining contract.

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Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered twice per 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) is covered twice per year. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12. Periodontal maintenance is covered four times per year. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and over, topical application of fluoride is covered twice per year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam, composite, and gold fillings, and inlays for the treatment of decay. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is covered 4 times per year.

Major (Class 3 services)

- **Implants** Surgical placement and removal of implants are covered. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years.**Restorative** Cast restorations (including pontics) are covered once in a seven year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last seven years.
- **Occlusal guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.

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 (e.g. nitrous oxide) or any other euphoric drugs.
- 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 appointment charges.
- 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 Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Association.

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