ALPA DENTAL INSURANCE PLAN

Frequently Asked Questions

Updated January 2021

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BENEFIT INFORMATION QUESTIONS

I am considering the ALPA Dental Plan in lieu of my employer- sponsored dental plan. What should I consider in evaluating which plan will be better for me?
After you've compared the benefits and premiums under both dental plans, if you are considering the ALPA Dental Plan instead of your employer-sponsored plan, you should take into consideration that your contribution for the employer-sponsored plan is made on a pretax basis, but your premium payments for the ALPA Dental Plan will be made on a post-tax basis. If both plans provide exactly the same benefits levels and have exactly the same premiums, the ALPA Dental Plan will actually be more expensive due to the loss of the tax savings.

What coverage is available under ALPA's Dental Plan?
There are two coverage options available under the ALPA Dental Plan: Basic and Comprehensive. Both options offer coverage for preventive, diagnostic, and restorative services, and the Comprehensive option also includes coverage for orthodontic services. Insured through Anthem, the Dental Plan includes access to Anthem's extensive network of participating providers to maximize plan value, but you can visit any licensed dentist. For details regarding the benefits available under each option and the associated costs, please visit memberinsurance.alpa.org and click on Dental Insurance Plans under the ALPA Insurance Products tab.

How has my coverage changed under ALPA's Dental Plan with the move to Anthem dental?
Members that are enrolled under the Delta Dental plan as of 12/31/2020 will be switched to the Anthem Dental plan effective 1/1/2021. Members should not see any change or disruption in the current coverage they have in place. However, there is a slight possibility that a provider under Delta Dental could be considered out-of-network under the Anthem plan which could have an impact services provided. We are encouraging all members to visit **Anthem.com** and click **Find a Doctor/Find Care** to make sure their provider is still in the network before seeking services.

Is there a deductible my family must meet before I receive benefits?
Yes, under the Basic Plan, for all services including preventive, you must meet a $50 deductible per person, with a maximum family deductible of $150. Under the Comprehensive Plan, this deductible is waived for Diagnostic or Preventive services, but would need to be met for all other services.

How does the Calendar Year Maximum work?
A calendar year refers to a period of January 1 - December 31. Your annual maximum will start fresh each January 1.

Do I or my children have orthodontic coverage?
Under the Comprehensive Plan only, your dependent children through the age of 26, to the end of the calendar year, will be covered for braces at 50% to a lifetime maximum of $1,000 per child.

Are there any waiting periods?
Yes, if you or your dependents enroll in coverage after this initial enrollment period, there is a 12 month waiting period for Major Services and Prosthetics. These include crowns, bridges, dentures and implants. There are no additional waiting periods to receive benefits.

What happens if I am currently in treatment?
As an example, your dentist gave you a cost estimate for a crown while you were insured by Delta Dental, but the crown will not be placed until you're covered by Anthem.

In situations like this, Anthem will honor your former carrier's pre-estimate to cover the crown, but the covered amount will be determined based on your dentist's participation under the Dental Complete plan.

For all non-orthodontic services that started before the effective date of your dental plan, payment of a claim will be based on when the service was finished. When you submit your claim to Anthem for a Dental Complete plan, make sure to include your former plan's pre-estimate. Anthem will use that to decide coverage.

If you or your child are in the middle of an active orthodontic treatment, like having bands placed, the provider needs to give us a copy of the original claim. The claim should include the following:

- Treatment type (procedure number).
- Total fee for treatment.
- Number of months of treatment will take place.
- Provider's signature.

The payment amount is based on the number of months of active treatment that are left.

COORDINATION OF BENEFITS BETWEEN DENTAL PLANS QUESTIONS

I have dental coverage through my employer. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the dental plan that covers you as an active employee—your employer-sponsored plan in this case—is primary, and the ALPA Dental Plan is secondary.

I have dental coverage through my spouse's employer. Which dental plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the plan that covers you other than as a dependent, for example as an employee or policyholder, is primary to a plan that covers you as a dependent. If you elect coverage under the ALPA Dental Plan and are also covered as a dependent under your spouse's employer-sponsored plan, the ALPA Dental Plan, under which you are the policyholder, will be primary, and your spouse's plan will be secondary for your dental coverage. However, if you also cover your spouse under the ALPA Dental Plan, your spouse's employer-sponsored plan will be primary for your spouse's dental benefits and the ALPA Dental Plan will be secondary. For children who are covered under both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is generally the primary plan with regard to the children (unless a court order specifies otherwise if you are divorced or separated).

I am retired and have retiree dental coverage under my previous employer's dental plan. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Under the generally applicable coordination of benefits principles, if you are covered by one dental plan as a retiree and another as the policyholder, either plan could be primary. In such situations, the plan that has covered you for the longer period of time— your employer-sponsored retiree dental plan in this case—is usually considered primary.

I am retired and have dental coverage under an individual plan. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the plan that has covered you the longest would be primary, but you should confirm the coordination rules under your other dental plan before electing coverage under the ALPA Dental Plan.

I am retired and have dental coverage under my spouse's employer- sponsored dental plan for active employees. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the plan that covers you as a policyholder—the ALPA plan in this case—is primary to a plan that covers you as a dependent. You should, however, confirm the coordination rules under your spouse's employer-sponsored plan before electing coverage under the ALPA Dental Plan.

How does the ALPA Dental Plan coordinate benefits if I have other primary coverage and the ALPA Dental Plan is secondary?

If you have other dental coverage and the ALPA Dental Plan is secondary, it doesn't mean that your benefits are doubled. What it means is that you may enjoy lower out-of-pocket costs for your dental care. Anthem Dental works with the other dental carrier and your dental office to coordinate your benefits and ensure that the combined amount paid by both plans does not exceed the total amount the dentist has agreed to accept from Anthem.

Suppose, for example, that both your employer-sponsored plan and the ALPA Dental Plan provide two cleanings a year, each with 80% coverage. You would not be entitled to four cleanings per year, but you may have some cost savings. Assuming a charge of $100 for a cleaning is allowable under both plans, the employer-sponsored primary plan would pay $80, and then the ALPA Dental Plan, as secondary, would cover the remaining $20 that you would have had to pay out-of-pocket if you were only covered by the primary plan.

Note that in any case where a plan other than the ALPA Dental Plan would be secondary, you should determine how the other plan coordinates when secondary. Many plans, when secondary, will not pay additional benefits if the primary plan already paid as much as the secondary plan would have paid if primary. In other words, under this method, if the primary plan in the example above pays $80 for the cleaning (80% of a $100 covered expense), and the secondary plan would also have paid $80 for the same cleaning (80% of a $100 covered expense), no additional benefits would be payable by the secondary plan. The ALPA Dental Plan, as secondary payer, coordinates to 100% of a "covered expense", as determined by Anthem Dental, so the $20 out-of-pocket expense in this example would be covered.

How does orthodontia coverage or coverage for dental work in progress under the ALPA Dental Plan (Comprehensive option) coordinate with my employer-sponsored plan's orthodontia coverage?

As with all other benefits under the plan, the primary plan—your employer-sponsored plan in this case—will pay first, and then the ALPA Dental Plan, as secondary, will determine its liability and pay the amount not paid by the primary plan, subject to the applicable coinsurance and maximum lifetime benefit under the ALPA Dental Plan.

If you have a dental treatment that was started but not completed prior to enrollment in ALPA Dental Plan), Anthem Dental will pay benefits based on the treatment plan, the remaining months of treatment and taking into consideration the other carrier's payments, subject to the applicable coinsurance and maximum lifetime benefit under the ALPA Dental Plan.

In order to receive benefits for dental work in progress, like orthodontia, Anthem Dental will require you to send them a comprehensive Explanation of Benefits showing the payments made by you and your other dental insurance provider for the dental work in progress, and your treatment plan, so that Anthem Dental may coordinate your benefits with the payments already made to or by you.

Example:
Total Fee== $6,000.00 (12 months remaining of a 24 months treatment plan.)
$6,000.00 divided by 24 = $250.00 per month.
$250.00 x 12 = $3,000.00 (ineligible)
Coinsurance = 50%
$3,000.00 @ 50 % = $1,500.00
LTM = $1,000.00
Payment Amount: $1,000 LTM

I have supplemental dental insurance or dental HMO insurance through a Medicare supplemental plan. How does the ALPA Dental Plan coordinate benefits with my plan?
The ALPA Dental Plan will be considered primary over supplemental plans, including a supplemental Medicare plan.

ELIGIBILITY QUESTIONS

Who is eligible to enroll in ALPA's Dental Plan?
ALPA members in the following membership classes are eligible to enroll in the Dental Plan:

AC	Active Member
AP	Apprentice Member
AR	Reactivated Member
EA	Executive Active Member
EI	Executive Inactive Member
IP	Inactive Participant Member
RT	Retired Member
SI	Sick Inactive Member
F1	Furloughed Member
ML	Military Leave Member
PL	Personal Leave Member
GP	Grievance Pending Member

A member who enrolls in ALPA's Dental Plan may also enroll his/her spouse, domestic or civil union partner and any of the member's and spouse's or partner's children who will be under age 26 on the January 1 of the plan year of enrollment. For purposes of this FAQ, spouse means domestic or civil union partner of the same or opposite sex.

Can I enroll or re-enroll at any time during the policy year?
Yes. Coverage may be elected anytime through the year. However, rates are subject to an annual renewal date of Jan 1st. There is also a 12-month waiting period on all major services for all new enrollments.

I have applied for coverage by the open enrollment deadline. When will my coverage be effective?
There is no longer an annual open enrollment. However, if you want your coverage to have a Jan 1st effective date, you must enroll no later than December 31st. All enrollments or changes will be effective on the first of the month following the date of approval and processing of the change in your billing statement.

What happens to spouse and dependent coverage upon termination of a member's coverage?
In most cases, if a member's coverage terminates, spouse and dependent coverage will also terminate at the end of the month following the termination date. However, a surviving spouse and any other covered dependents of a deceased member may continue participation by electing to participate in COBRA. Members and their families (qualified beneficiary/ies) are offered the opportunity for a temporary extension of coverage at group rates where coverage under the plan would otherwise end. Members, spouse, and dependents have a right to choose COBRA (within 60 days of the event) if they lose their group dental coverage. The COBRA Administrator will provide for direct billing and annual open enrollment for the COBRA plans.

When does coverage end for a covered child?
Coverage for children ends at the end of the calendar year in which they turn age 26. At the end of the child coverage, the covered child can elect to continue coverage under COBRA.

How does the Dental Plan apply to members on military leave?
Eligible members on military leave are able to enroll and participate in the Dental Plan or make changes according to the qualifying life event change rules. Members on military leave also may suspend coverage in the Dental Plan upon commencement of military leave and reinstate coverage as of the first of the month following return from military leave.

Can my dependent(s) enroll without me?
No. Members must enroll in order for dependents to have coverage, and all covered family members must be enrolled in the same Dental Plan option.

If I enroll in the Dental Plan, can I cover only certain dependents? For example, if my spouse has coverage through his or her employer, can I just enroll myself and my child(ren)?
Yes. Any eligible dependent(s) can be covered upon your initial eligibility or added anytime throughout the year. 12-month waiting period on major services will apply.

What happens if my ALPA membership classification changes from an eligible to an ineligible membership class?
When a member moves into an ineligible class, coverage for the member (including the member's spouse and any covered dependents) will terminate at the end of the month following the change in membership status. Members and their families (qualified beneficiary/ies) are offered the opportunity for a temporary extension of coverage at group rates where coverage under the plan would otherwise end. Members, spouse, and dependents have a right to choose COBRA (within 60 days of the event) if they lose their group dental coverage. The COBRA Administrator will provide for direct billing and annual open enrollment for the COBRA plans.

How can my cancelled ALPA dental coverage be reinstated?
Coverage cancelled due to premium delinquency can be reinstated at any time provided all delinquent premiums are paid in full. If the member decides not to reinstate and re-enroll at a later date, member will not be allowed to re-enroll unless the prior delinquency is paid in full.

DENTAL NETWORK QUESTIONS

How do I check to see if a dentist is in the plan?

- *Step 1:* Visit anthem.com and click Find a Doctor/Find Care.
- *Step 2: Click the Change State button and choose the state where you are seeking dental care*
- *Step 3: Click the "Guests" button*
- *Step 4: Enter the following criteria, then click the Continue button:*
    - *Type of Care: Dental*
    - *State: Choose the state*
    - *Type of Plan: Dental*
    - *Plan/Network: Scroll down and choose "Dental Complete"*
- *Step 5: In the search bar, enter the zip code or type of dentist, name or license number. If you want to search for all providers, scroll down slightly and click on "Dental Professionals"*
- *Step 6: Review the search results. You can either print a copy of the search results or email them.*

Why should I use a dentist in my plan's network?
You will save money two ways:

- Dentists in your plan charge less.
- They cannot balance bill you. So, if for some reason, they charge more than what they're supposed to, they cannot bill you for the difference between what we pay them and what they charge.

Also, you will save time and have less hassle because your dentist will file claims for you. If you use an out-of-network dentist you may have to pay the dentist first, and then submit the claim to Anthem.

What happens if I use an out of network provider?
Your out of network reimbursement is at the 90th percentile. For example, the 90th percentile means that 90% of providers in a given zip code area charge at or below the fee that will be used by Anthem for reimbursement.

If the dentist charges at or lower than the percentile used, your benefits (coinsurance, maximum and deductibles) are based on the dentist's billed charge for the service.

If the dentist charges higher than this allowable fee, you will be responsible for any amount above this allowable fee and the allowable amount determined by Anthem.

What if I need dental care if I'm traveling outside the United States?
As an Anthem dental member, you and your family have access to the International Emergency Dental Program. With this program, you may get emergency dental care from our list of credentialed, English-speaking dentists while traveling or working abroad.

MISCELLANEOUS QUESTIONS

How can I obtain a dental identification card?
Once you are enrolled, a set of two ID cards will automatically be sent to you. You may request a replacement or additional ID cards through the Anthem Dental member portal or mobile app.

How do I log in to the Dental Member Services portal?
You can log into the member portal http://www.anthem.com or download and use the Anthem Sydney Mobile app. Either will be available on your effective date of January 1, 2021.

What can I do on the Dental Member Services portal?
The dental member services portal is the way to go for benefits, advice and much more! Here are a few examples of things you can do on the portal:

- Find a dentist
- Order extra ID cards
- Find out the status of a claim
- Use the **Dental Health Assessment** tool to determine your "health score" for your teeth and gums and find out if you're at risk for oral cancer.
- See how much a treatment may cost with our **Dental Cost Estimator** tool.
- Get personal advice through our **Ask a Hygienist** email link.

Who do I call if I have questions?
Call the customer service number on the back of your ID card.