

Delta Dental PPO Plan Benefit Summary



Delta Dental of Oregon & Alaska

Cement Masons - Plan design 1

Group ID: 10001724

PPO Plan			
	In-Network PPO Provider	In-Network Premier Provider	Out-of-Network Non-Participating Provider
Calendar year costs			
Annual Maximum, per member		\$1,500	
Calendar year deductible, per member		\$50	\$100
Calendar year maximum deductible, per family		\$150	\$300
Class 1*			
Periodic Examinations / X-rays	100%	100%	80%
Prophylaxis (cleanings) / Periodontal Maintenance	100%	100%	80%
Sealants	100%	100%	80%
Space Maintainers	100%	100%	80%
Topical Application of Fluoride	100%	100%	80%
Class 2			
Restorative Fillings	80%	80%	80%
Oral Surgery (extractions & certain minor surgical procedures)	80%	80%	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%	80%	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%	80%	80%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive.

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 or Premier dentist from our directory which is on our website at www.modahealth.com. Each family member may choose a different dentist. If you receive care from a dental provider not in either of the Delta Dental Networks, Out-of-Network coverage levels will apply.

When the member visits:

Delta Dental PPO and Premier Dentists:

Benefits are paid at the In Network 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, or filed 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.

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 once in any 6-month period. Supplementary bitewing x-rays are covered once every 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period as part as evidence based dental dentistry.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 18 and under. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a 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** If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference. 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 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. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Night Guard** (occlusal guard) covered at 100%; no deductible up to a maximum of \$150. Repairs and relines are not covered within initial 6 month period, repairs and relines are only covered once in every 12 month period. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, 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.

Exclusions

- ViziLite Plus TBlue is no longer a covered benefit. With more recent evidence based results, the initial findings of the effectiveness of ViziLite Plus TBlue turn out to be inconclusive.
- 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.
- 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 his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services.
- 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.



Delta Dental of Oregon

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Group #10001724

Dental Customer Service

503-265-2965 or 800-452-1058, dental@modahealth.com

Customer Service hours

Monday through Friday, 7:30 a.m. - 5:30 p.m. PST

modahealth.com

