# 2020 Delta Dental PPO Plan Benefit Summary

## Passive Preferred Option Plan BP3X50

<table>
<thead>
<tr>
<th>Calendar year costs</th>
<th>PPO provider</th>
<th>Premier provider</th>
<th>Out-of-network non-participating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar year maximum, per member</td>
<td></td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Calendar year deductible, per member</td>
<td>$50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar year maximum deductible, per family</td>
<td>$150</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Class 1*

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO provider</th>
<th>Premier provider</th>
<th>Out-of-network non-participating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic examinations / x-rays</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylaxis (cleanings) / periodontal maintenance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Topical application of fluoride</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Class 2

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO provider</th>
<th>Premier provider</th>
<th>Out-of-network non-participating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorative fillings</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral surgery (extractions &amp; certain minor surgical procedures)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (treatment of teeth with diseased or damaged nerves)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics (treatment of diseases of the gums and supporting structures of the teeth)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Class 3

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO provider</th>
<th>Premier provider</th>
<th>Out-of-network non-participating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crowns and other cast restorations</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

* 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 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 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.
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 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 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 under age 19. 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 Amalgam and composite fillings are covered for all teeth. 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.
- Occlusal Guard (night guard) covered at 100% once in a five year period, up to $150 maximum. 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
- 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 his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- 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.
Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:

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).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda’s efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 15019019 (8/16)
ATENCIÓN: Si habla español, hay disponibilidades de servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您说中文，可得到免费语言帮助服务。请致电1-877-605-3229（免贵人专用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY: 711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 번호로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyon tulong sa wika, ayan walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تحذير: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متوفرة للحالات التصل بالرقم 1-877-605-3229 (النواحي النصية: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofi sèvis gratis pou ede w nan lang ou pale a. Rele non 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION: si vous êtes locuteurs francophones, le service d’assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY: 711)


ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY: 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rou 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือในภาษาได้ ทางโทร 1-877-605-3229 (TTY: 711)

מברשות: אם אתם מדברים עברית, ניתן להזמין שירות תרגום בבלוגרילית בברירת מחדל. ניתן לتصل באמצעות המספר 1-877-605-3229 (TTY: 711)

HUBACHIIISA: Yoo afano Kshtik kan dubbattan ta’e taajagiloonnii gargaarsaa isinii jira 1-877-605-3229(TTY:711) tin bibilaab.