2027 Dental Plan Benefit Summary

Delta Dental of Oregon & Alaska

Salem Health

Group ID: 10001832

Dental + Orthodontia Plan

	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year benefit maximum, per member	$1,500		
Calendar year deductible, per member	$25		
Calendar year deductible, 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	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%
Orthodontia*			
Adult and child orthodontic services	50% up to a $1,500 lifetime maximum		

* Deductible does not apply to Class 1 services or Orthodontia. Preventive care other than cone beam x-rays does not accumulate to the annual maximum.

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.deltadentalor.com. Each family member may choose a different dentist.

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:
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 twice per year. Supplementary bitewing x-rays are covered once per year. 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 year. 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 twice per year for members under age 19. For members age 19 and older, topical application of fluoride is covered twice per year 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 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 limited to once per quadrant in any 24-month 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 7-year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a 7-year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 7 years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal guard** (night guard) covered at 100% once in a 5-year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouthguard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 2-year period for 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 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 Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Association.