2024 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

City of Salem

Group ID: 10000159

Incentive Plan

Calendar year costs	
Calendar year maximum, per member	$1,000
Calendar year deductible, per member	$0
Class 1	
Periodic examinations / X-rays	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Prophylaxis (cleanings) / periodontal maintenance	
Sealants	
Space maintainers	
Topical application of fluoride	
Class 2 & 3	
Restorative fillings	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Crowns and other cast restorations	
Class 4	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%

* Under this plan, payments increase by 10% each eligibility year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment the following year, although payment will never fall below 70%.

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:

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.

Delta Dental of Oregon & Alaska

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 calendar year. Supplementary bitewing x-rays are covered once in a 12-month period. Complete series x-rays or a panoramic film are covered once every 5 years.
- **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 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 except for evidence of clinical failure.
- **Space Maintainers** are a benefit once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.

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)

- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.

Major (Class 4 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.
- **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 $200 maximum. Repairs and relines and adjustment of occlusal guard covered once in every 12 month period. Over-the-counter night guards are excluded. 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 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.

Delta Dental orthodontia rider

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Adult & Child Ortho 1000	
Lifetime maximum	$1,000
	What members pay
Members age 19+	50%
Members under age 19	50%

Eligible Employees and their covered dependents

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

Pre-determination

Your dental office can submit a pre-treatment plan to Delta Dental of Oregon on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

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