

Delta Dental of Oregon  
Plus Plan Benefit Summary  
adidas America, Inc.  
Group ID: 10015898



Delta Dental of Oregon & Alaska

Effective 01/01/2025

| Delta Dental Plus Plan  |                 |                     |                                   |
|---|-----------------|---------------------|-----------------------------------|
|   | PPO<br>Provider | Premier<br>Provider | Non-<br>Participating<br>Provider |
| <b>Calendar year costs</b>  |                 |                     |                                   |
| Annual Maximum, per member (Class 2 and Class 3 services)   |                 | \$1,500             |                                   |
| Calendar year deductible, per member  |                 | \$25                |                                   |
| Calendar year maximum deductible, per family  |                 | \$75                |                                   |
| <b>Class 1* (Services do not apply to the annual maximum)</b>                                     |                 |                     |                                   |
| 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%                              |
| <b>Class 2</b>  |                 |                     |                                   |
| 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<br>(treatment of diseases of the gums and supporting structures of the teeth)        | 80%             | 80%                 | 80%                               |
| <b>Class 3</b>  |                 |                     |                                   |
| Implants  | 75%             | 75%                 | 75%                               |
| Crowns and other cast restorations  | 75%             | 75%                 | 75%                               |
| Dentures and bridges<br>(construction or repair of fixed bridges, partial, and complete dentures) | 75%             | 75%                 | 75%                               |

\* 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

Through Delta Dental PPO and Premier networks, we set limits on what dentists can charge for certain services. You'll save the most when you visit a Delta Dental PPO provider. They agree to accept our lowest contracted rates as full payment. Both Delta Dental networks protect you from 'balance billing' the practice of billing you for the difference between your dentist's fees and the rates your dental plan will pay.

## When the member visits:

### Delta Dental PPO Dentists:

When you visit a Delta Dental PPO dentist you will have the lowest cost and the most savings. Members are held harmless from balance billing.

### Delta Dental Premier Dentist, Non PPO:

When you visit a Delta Dental Premier dentist you will have slightly higher costs with some savings. Members are held harmless from balance billing.

### Non-Participating Dentists:

When you visit a Non-participating dentist benefits are paid up to the maximum plan allowable (MPA). 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, comprehensive examinations and consultations are covered twice per calendar year. Supplementary bitewing x-rays are covered twice per calendar year. Complete series x-rays or a panoramic film are covered once in any 5-year period. Single tooth x-rays are covered as needed.
- **Preventive** Prophylaxis (cleanings) are covered 3 per calendar year. Periodontal maintenance is covered for members with periodontal disease, once every 3 months. Prophylaxis and Periodontal maintenance will check against each other not to exceed a total of 4 cleanings 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.

## Basic (Class 2 Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered on all teeth.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period. No more than 2 quadrants per date of service.

## Major (Class 3 Services)

- **Restorative** Cast restorations (including pontics) are covered once in 60 months on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in 60 months, only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 60 months. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Night Guard** (occlusal guard) covered at 100%; no deductible, once in a five year period, up to \$200 maximum. Over the counter occlusal guards are not covered.
- **Athletic mouth guard** covered at 100%, up to \$150 max, 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.
- 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.
- 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



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| Delta Dental Plus Plan Orthodontia |                  |
|------------------------------------|------------------|
| Lifetime maximum                   | \$2,000          |
|                                    | What members pay |
| Members age 19+                    | 50%              |
| Members under age 19               | 50%              |

### How to use this dental plan

When you visit your dental provider, tell him or her 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.