

## **Request for Proposal for Broker Services and Group Health renewal options**

October 28, 2024

Response Due Date: November 14, 2024

### **Contact Information:**

Debbie Scacco, Port Manager

[Debbie.scacco@portoftoledo.org](mailto:Debbie.scacco@portoftoledo.org)

Phone: 541-336-5207

The Port of Toledo is a Special District operating as a competitive business enterprise as well as a public service agency. By direction of the Board, the Port is seeking proposals from a Broker with group Health renewal options. Our current policy expires May 31, 2025, but the Port is considering changing to a January renewal date and wishes to review renewal options for January 1, 2025. Our goal is to improve the quality of care and manage costs effectively. Employee demographics and current plan summaries are attached (the last two medical plans are buy-up options).

### **Scope of Work**

The selected Broker will be responsible for the following services:

- Provide market analysis/Benefit Education
- Benefit comparison review from available options: Providing the most affordable care to the Port of Toledo while limiting individual out of pocket costs.
- Enrollment assistance
- Identify areas that need to be evaluated to control insurance costs.

### **Proposal Requirements**

Interested Brokers should submit a proposal that includes the following:

- Describe your organization, including size, location, and years in operation. If Special District experience.
- Pricing Structure: Include a detailed pricing model, specifying any variable costs, health, vision and dental plan options.
- References: Provide at least three references from similar clients or projects.

### **Evaluation Criteria**

Proposals will be evaluated based on the following criteria:

- Quality and comprehensiveness of the proposed services.
- Cost-effectiveness and clarity of pricing structure, including management fee by Broker.
- Any additional services presented in detail i.e. HRA, COBRA, Aflac etc.....
- Brokers experience with similar group entities.

### **Submission Instructions**

Please submit your proposal electronically to [info@portoftoledo.org](mailto:info@portoftoledo.org) by November 12, 2024. Late submissions will not be considered.

We look forward to receiving your proposal and appreciate your interest in partnering with the Port of Toledo to enhance our health care services.

Group ID	Group Name	First Name	Date Of Birth	Zip	Gender	Family Tier
10011878	Port of Toledo	Les	12/07/1981	97341	M	Subscriber Only
10011878	Port of Toledo	Darcy	06/23/1961	97391	F	Subscriber Only
10011878	Port of Toledo	Ethan	08/16/1991	97391	M	Subscriber Only
10011878	Port of Toledo	Debora	12/12/1967	97326	F	Subscriber & Spouse
10011878	Port of Toledo	Mark	01/25/1968	97326	M	Spouse Dental Only
10011878	Port of Toledo	Daniel	06/22/1978	97391	M	Subscriber Only
10011878	Port of Toledo	Deward	06/06/1976	97357	M	Subscriber Only
10011878	Port of Toledo	Juan	06/22/1983	97365	M	Subscriber Only
10011878	Port of Toledo	Chris	10/24/1978	97365	M	Subscriber Only
10011878	Port of Toledo	Dana	03/01/1960	97467	M	Family
10011878	Port of Toledo	Lisa	07/22/1965	97467	F	Family - Dental Only
10011878	Port of Toledo	Anthony	04/11/1986	97391	M	Subscriber Only
10011878	Port of Toledo	Leslie	08/02/1962	97380	M	Subscriber Only
		Dakota	6/18/1990	97391	M	Subscriber Only
		Enrique	8/15/1986	97391	M	Subscriber Only
		Crystal	5/8/1978	97366	F	Subscriber Only
10011878	Port of Toledo	Corey	11/04/1969	97391	M	Subscriber Only

**COBRA DENTAL ONLY**

10011878	Port of Toledo	Adam	08/09/1982	97391	M	Subscriber & Spouse
10011878	Port of Toledo	Stephanie	01/18/1982	97391	F	Spouse Dental Only

# 2024 Medical plan benefit summary

## ● Connexus Silver 3500

	In network you pay	Out-of-network you pay
<b>Calendar year costs</b>		
Deductible per person	\$3,500	\$5,000
Deductible per family	\$7,000	\$10,000
Out-of-pocket max per person	\$9,100	\$10,000
Out-of-pocket max per family	\$18,200	\$20,000
<b>Care &amp; services</b>		
Preventive care visit	\$0/visit	50% after deductible
Primary care provider (PCP) office visit <sup>1</sup>	\$50/visit	50% after deductible
Specialist office visit	\$70/visit	50% after deductible
Urgent care visit	\$70/visit	50% after deductible
Virtual care visit – CirrusMD	\$0/visit	Not Covered
Other providers	\$10/visit	50% after deductible
Outpatient diagnostic X-ray & lab	40%	50% after deductible
Emergency room visit	\$400 after deductible	\$400 after deductible
Ambulance	40% after deductible	40% after deductible
Inpatient/outpatient Care	40% after deductible	50% after deductible
Outpatient mental health/ substance use disorder visit <sup>1</sup>	\$50/visit	50% after deductible
Physical, speech or occupational therapy visit	\$50/visit	50% after deductible
Acupuncture and spinal manipulation services	\$50/visit	50% after deductible
Pediatric vision exam	\$50/visit	50% after deductible
Pediatric vision hardware	40%	50% after deductible
<b>Prescription medications<sup>2</sup></b>		
Value	\$2	\$2
Select	\$20	\$20
Preferred	\$70	\$70
Non-Preferred	50%	50%
Preferred Specialty	25% after deductible	Not Covered
Non-Preferred Specialty	50% after deductible	Not Covered
<b>Features</b>		
Metallic level	Silver	
Exchange	Off	
Medicare Part D creditable	Creditable	
Provider network	Connexus	
Travel network	Aetna PPO	
Service area	Statewide	

<sup>1</sup> First 3 visits (including in person or virtual primary care visits and mental health and substance use disorder visits) \$5/visit

<sup>2</sup> One copay per 30-day supply. \$85 maximum per 30-day supply for insulin

## Limitations

- Acupuncture: 12 visits per year
- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback: Only for tension or migraine headaches or urinary incontinence. 10 visits per lifetime
- Coordination of benefits: When you have more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services. If the group is less than 20 employees, any expense that is paid under Medicare will have benefits reduced by the amount Medicare paid
- Hearing aids: Once every 3 years. Hearing tests: Twice per year under age 4 and once per year age 4 and older
- Hospice respite care: 30 days per lifetime, up to five days in a row
- Infusion therapy: For some medications you must use an authorized provider. Outpatient hospital setting may not be covered
- Prescriptions: 30-day supply for standard retail and most specialty pharmacy. 90-day supply for mail order and participating retail
- Preventive care: Cost sharing may apply to services not required under the Affordable Care Act. Only women's exam, Pap test, mammogram, prostate exam and PSA test are covered out-of-network
- Rehabilitation and habilitation: 30 inpatient days and 30 outpatient sessions per calendar year. Extra rehabilitation up to 60 days after acute head or spinal cord injury or 60 sessions to treat neurologic conditions. Separate limits for rehabilitative and habilitative services.
- Skilled nursing facility: 60 days per year
- Spinal manipulation: 20 visits per year
- Transplants must be performed at the authorized transplant facility to be eligible for coverage
- Vision exam and glasses or contacts: Once per year for members under age 19

## Exclusions

- Care outside the United States, other than emergency care
- Charges over the maximum plan allowance
- Correctional services, including sheltered living and court-ordered anger management or sex offender treatment
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Custodial care
- Dental examinations and treatment except for accidental injury
- Experimental or investigational treatment
- Infertility (services or supplies to treat infertility, including reversal of sterilization)
- Injury you get from practicing for or participating in professional athletic activities
- Instruction programs, except under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies. Includes herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements
- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery except when medically necessary to repair an accidental injury or for treatment of cancer
- Self-treatment. Services you provide to yourself or services from a member of your immediate family (other than a dental provider)
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to cure or reduce near-sightedness, far-sightedness or astigmatism

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# 2024 Dental plan benefit table

Delta Dental Premier, PF, 1500, 100/80/50, 50	Ages 0-18, employees pay	Ages 19+, employees pay
Calendar year costs		
Deductible	\$50 per person / \$150 family	
Annual maximum (age 19+)	\$1500 Class 1 does not apply to max	
Out-of-pocket maximum (under age 19)	\$400 for one member \$800 for two or more members	
Class 1 <sup>1</sup>		
Exams and X-rays	10%	0%
Cleanings	10%	0%
Sealants	10%	0%
Topical fluoride	10%	0% <sup>3</sup>
Space maintainers	10%	Not covered
Class 2		
Restorative fillings	30% after deductible	20% after deductible
Oral Surgery	30% after deductible	20% after deductible
Endodontics	30% after deductible	20% after deductible
Periodontics	30% after deductible	20% after deductible
Anesthesia	30% after deductible	20% after deductible
Class 3		
Restorative crowns	50% after deductible	50% after deductible
Partial and complete dentures	50% after deductible	50% after deductible
Implants & bridges	Not covered	50% after deductible
Orthodontia <sup>2</sup>	50% after deductible	Not covered
Features		
Provider Network	Delta Dental Premier Network	
Balance bill	Participating dentists: no Nonparticipating dentists: yes	
Direct Option plan match	Direct Option 3K-3KK	

<sup>1</sup> Deductible waived for class 1 services.

<sup>2</sup> Only medically necessary orthodontia to treat cleft palate is covered.

<sup>3</sup> Covered once in a 12-month period if there is a recent history of periodontal surgery or high-risk of decay because of medical disease or chemotherapy or similar type of treatment.

## Limitations

### Class 1

- Bitewing X-rays once in a 12-month period
- Exam once in a 6-month period
- Fluoride once in a 6-month period under age 19 and once every 12 months if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment for age 19 and over
- Full-mouth or panoramic X-rays once in a 5-year period
- Interim caries arresting medicament application is covered twice per tooth per year. Many restorations are not covered within 2 months of interim caries arresting medicament application.
- Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of two additional periodontal maintenances per year.
- Sealants limited to unrestored occlusal surface of permanent molars once per tooth in a 5-year period except for evidence of clinical failure

### Class 2 and Class 3

- Athletic mouthguard once in any 12-month period for members age 15 and under and once in any 2-year period age 16 and over
- Bridges once in a 7-year period age 19 and over
- Crowns and other cast restorations once in a 7-year period
- Crown-over-implant once per lifetime per tooth space
- Dentures once in a 7-year period age 16 and over
- IV sedation or general anesthesia only with surgical procedures
- Nightguard (occlusal guard) covered at 100% once in a 5 year period, up to \$200 maximum
- Oral anesthesia medication permitted for members under age 19 when used during an in-office procedure
- Periodontal surgical procedures by the same dentist at the same site are covered once in a 3 year period for members 19 and over
- Porcelain crowns on back teeth are limited to the amount for a full metal crown
- Scaling and root planing once in a 2-year period

## Exclusions

- Anesthetics, analgesics, hypnosis and medications, including nitrous oxide for adults
- Bridges not covered under age 19
- Charges above the maximum plan allowance
- Charting (including periodontal, gnathologic)
- Congenital or developmental malformations
- Cosmetic services
- Duplication and interpretation of X-rays or records
- Experimental or investigational treatment
- Hospital costs or other fees for facility or home care except for emergency care for members under age 19
- Implants under age 19
- Instructions or training (including plaque control and oral hygiene or dietary instruction)
- Orthodontia (exception for treatment of cleft palate under age 19)
- Over-the-counter athletic mouthguards and nightguards
- Precision attachments
- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth
- Self treatment
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Temporomandibular joint syndrome (TMJ)
- Translation or sign language services are not covered as separate charges
- Treatment before coverage begins or after coverage ends
- Treatment not dentally necessary

These benefits and Delta Dental of Oregon policies are subject to change in order to be compliant with state and federal guidelines. This document provides summaries of various dental plans and is not a contract. If there is any discrepancy between the summaries and the contract, it is the contract that will control. Dental plans in Oregon provided by Delta Dental of Oregon. Delta Dental is a trademark of Delta Dental Plans Association.

# 2024 Vision plan benefit summary



Vision \$400 Max	
Benefit maximum	\$400
	What members pay
Eye examinations (including refraction)	0%
Lenses	0%
Frames	0%

## Limitations and exclusions for vision plans

- Vision plan benefits are limited to members age 19 and older
- Vision exam and hardware benefits are all subject to the calendar-year benefit maximum.
- Non-covered, excluded services are the member's responsibility and do not apply toward the calendar-year benefit maximum.
  - a. Special procedures such as orthoptics and vision training
  - b. Nonprescription lenses
  - c. Medical or surgical treatment of the eyes

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[modahealth.com](http://modahealth.com)

# 2024 Medical plan benefit summary



## ● Connexus Gold 1500

	In network you pay	Out-of-network you pay
<b>Calendar year costs</b>		
Deductible per person	\$1,500	\$5,000
Deductible per family	\$3,000	\$10,000
Out-of-pocket max per person	\$8,550	\$10,000
Out-of-pocket max per family	\$17,100	\$20,000
<b>Care &amp; services</b>		
Preventive care visit	\$0/visit	50% after deductible
Primary care provider (PCP) office visit <sup>1</sup>	\$30/visit	50% after deductible
Specialist office visit	\$50/visit	50% after deductible
Urgent care visit	\$50/visit	50% after deductible
Virtual care visit – CirrusMD	\$0/visit	Not Covered
Other providers	\$10/visit	50% after deductible
Outpatient diagnostic X-ray & lab	25%	50% after deductible
Emergency room visit	\$300 after deductible	\$300 after deductible
Ambulance	25% after deductible	25% after deductible
Inpatient/outpatient Care	25% after deductible	50% after deductible
Outpatient mental health/ substance use disorder visit <sup>1</sup>	\$30/visit	50% after deductible
Physical, speech or occupational therapy visit	\$30/visit	50% after deductible
Acupuncture and spinal manipulation services	\$30/visit	50% after deductible
Pediatric vision exam	\$30/visit	50% after deductible
Pediatric vision hardware	25%	50% after deductible
<b>Prescription medications<sup>2</sup></b>		
Value	\$2	\$2
Select	\$10	\$10
Preferred	\$50	\$50
Non-Preferred	50%	50%
Preferred Specialty	25%	Not Covered
Non-Preferred Specialty	50%	Not Covered
<b>Features</b>		
Metallic level	Gold	
Exchange	Off	
Medicare Part D creditable	Creditable	
Provider network	Connexus	
Travel network	Aetna PPO	
Service area	Statewide	

<sup>1</sup> First 3 visits (including in person or virtual primary care visits and mental health and substance use disorder visits) \$5/visit

<sup>2</sup> One copay per 30-day supply. \$85 maximum per 30-day supply for insulin



## Limitations

- Acupuncture: 12 visits per year
- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback: Only for tension or migraine headaches or urinary incontinence. 10 visits per lifetime
- Coordination of benefits: When you have more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services. If the group is less than 20 employees, any expense that is paid under Medicare will have benefits reduced by the amount Medicare paid
- Hearing aids: Once every 3 years. Hearing tests: Twice per year under age 4 and once per year age 4 and older
- Hospice respite care: 30 days per lifetime, up to five days in a row
- Infusion therapy: For some medications you must use an authorized provider. Outpatient hospital setting may not be covered
- Prescriptions: 30-day supply for standard retail and most specialty pharmacy. 90-day supply for mail order and participating retail
- Preventive care: Cost sharing may apply to services not required under the Affordable Care Act. Only women's exam, Pap test, mammogram, prostate exam and PSA test are covered out-of-network
- Rehabilitation and habilitation: 30 inpatient days and 30 outpatient sessions per calendar year. Extra rehabilitation up to 60 days after acute head or spinal cord injury or 60 sessions to treat neurologic conditions. Separate limits for rehabilitative and habilitative services.
- Skilled nursing facility: 60 days per year
- Spinal manipulation: 20 visits per year
- Transplants must be performed at the authorized transplant facility to be eligible for coverage
- Vision exam and glasses or contacts: Once per year for members under age 19

## Exclusions

- Care outside the United States, other than emergency care
- Charges over the maximum plan allowance
- Correctional services, including sheltered living and court-ordered anger management or sex offender treatment
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Custodial care
- Dental examinations and treatment except for accidental injury
- Experimental or investigational treatment
- Infertility (services or supplies to treat infertility, including reversal of sterilization)
- Injury you get from practicing for or participating in professional athletic activities
- Instruction programs, except under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies. Includes herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements
- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery except when medically necessary to repair an accidental injury or for treatment of cancer
- Self-treatment. Services you provide to yourself or services from a member of your immediate family (other than a dental provider)
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to cure or reduce near-sightedness, far-sightedness or astigmatism

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# 2024 Medical plan benefit summary



## ● Connexus Platinum 500

	In network you pay	Out-of-network you pay
<b>Calendar year costs</b>		
Deductible per person	\$500	\$3,000
Deductible per family	\$1,000	\$6,000
Out-of-pocket max per person	\$3,000	\$10,000
Out-of-pocket max per family	\$6,000	\$20,000
<b>Care &amp; services</b>		
Preventive care visit	\$0/visit	50% after deductible
Primary care provider (PCP) office visit <sup>1</sup>	\$15/visit	50% after deductible
Specialist office visit	\$30/visit	50% after deductible
Urgent care visit	\$30/visit	50% after deductible
Virtual care visit – CirrusMD	\$0/visit	Not Covered
Other providers	\$10/visit	50% after deductible
Outpatient diagnostic X-ray & lab	10%	50% after deductible
Emergency room visit	\$250 after deductible	\$250 after deductible
Ambulance	10% after deductible	10% after deductible
Inpatient/outpatient Care	10% after deductible	50% after deductible
Outpatient mental health/ substance use disorder visit <sup>1</sup>	\$15/visit	50% after deductible
Physical, speech or occupational therapy visit	\$15/visit	50% after deductible
Acupuncture and spinal manipulation services	\$15/visit	50% after deductible
Pediatric vision exam	\$15/visit	50% after deductible
Pediatric vision hardware	10%	50% after deductible
<b>Prescription medications<sup>2</sup></b>		
Value	\$2	\$2
Select	\$10	\$10
Preferred	\$30	\$30
Non-Preferred	50%	50%
Preferred Specialty	25%	Not Covered
Non-Preferred Specialty	50%	Not Covered
<b>Features</b>		
Metallic level	Platinum	
Exchange	Off	
Medicare Part D creditable	Creditable	
Provider network	Connexus	
Travel network	Aetna PPO	
Service area	Statewide	

<sup>1</sup> First 3 visits (including in person or virtual primary care visits and mental health and substance use disorder visits) \$5/visit

<sup>2</sup> One copay per 30-day supply. \$85 maximum per 30-day supply for insulin

## Limitations

- Acupuncture: 12 visits per year
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- Biofeedback: Only for tension or migraine headaches or urinary incontinence. 10 visits per lifetime
- Coordination of benefits: When you have more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services. If the group is less than 20 employees, any expense that is paid under Medicare will have benefits reduced by the amount Medicare paid
- Hearing aids: Once every 3 years. Hearing tests: Twice per year under age 4 and once per year age 4 and older
- Hospice respite care: 30 days per lifetime, up to five days in a row
- Infusion therapy: For some medications you must use an authorized provider. Outpatient hospital setting may not be covered
- Prescriptions: 30-day supply for standard retail and most specialty pharmacy. 90-day supply for mail order and participating retail
- Preventive care: Cost sharing may apply to services not required under the Affordable Care Act. Only women's exam, Pap test, mammogram, prostate exam and PSA test are covered out-of-network
- Rehabilitation and habilitation: 30 inpatient days and 30 outpatient sessions per calendar year. Extra rehabilitation up to 60 days after acute head or spinal cord injury or 60 sessions to treat neurologic conditions. Separate limits for rehabilitative and habilitative services.
- Skilled nursing facility: 60 days per year
- Spinal manipulation: 20 visits per year
- Transplants must be performed at the authorized transplant facility to be eligible for coverage
- Vision exam and glasses or contacts: Once per year for members under age 19

## Exclusions

- Care outside the United States, other than emergency care
- Charges over the maximum plan allowance
- Correctional services, including sheltered living and court-ordered anger management or sex offender treatment
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Custodial care
- Dental examinations and treatment except for accidental injury
- Experimental or investigational treatment
- Infertility (services or supplies to treat infertility, including reversal of sterilization)
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- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery except when medically necessary to repair an accidental injury or for treatment of cancer
- Self-treatment. Services you provide to yourself or services from a member of your immediate family (other than a dental provider)
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# 2024 Vision plan benefit summary



Vision \$400 Max	
Benefit maximum	\$400
	What members pay
Eye examinations (including refraction)	0%
Lenses	0%
Frames	0%

## Limitations and exclusions for vision plans

- Vision plan benefits are limited to members age 19 and older
- Vision exam and hardware benefits are all subject to the calendar-year benefit maximum.
- Non-covered, excluded services are the member's responsibility and do not apply toward the calendar-year benefit maximum.
  - a. Special procedures such as orthoptics and vision training
  - b. Nonprescription lenses
  - c. Medical or surgical treatment of the eyes

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[modahealth.com](https://modahealth.com)

Health plans in Oregon provided by Moda Health Plan, Inc.  
0817 (8/23)

## Direct Option 3K and 3KK – Willamette Dental Group

Benefit	Under age 19, members pay	Ages 19+, members pay
Annual maximum	No annual maximum	No annual maximum
Deductible	No deductible	No deductible
Annual out of pocket limit	\$400 – 1 child \$800 – 2 or more children	Not applicable
General office visit	\$15 per visit	\$15 per visit
<b>Diagnostic and preventive services</b>		
Routine and emergency exams	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Routine X-rays	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Teeth cleaning	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Fluoride treatment	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Sealants (per tooth)	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Head and neck cancer screening	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Oral hygiene instruction	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Periodontal charting	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Periodontal evaluation	Covered with the Office Visit Copay	Covered with the Office Visit Copay
<b>Restorative dentistry and prosthodontics</b>		
Fillings	\$20	\$20
Porcelain-metal crown	\$150	\$150
Complete upper or lower denture	\$150	\$150
Bridge (per tooth)	\$150	\$150
Dental implant surgery	You pay charges in excess of \$1,500*	You pay charges in excess of \$1,500*
<b>Endodontics and periodontics</b>		
Root canal therapy – anterior	\$125	\$125
Root canal therapy – bicuspid	\$175	\$175
Root canal therapy – molar	\$225	\$225
Osseous surgery (per quadrant)	\$150	\$150
Root planing (per quadrant)	\$120	\$120
<b>Oral surgery</b>		
Routine extraction (single tooth)	\$20	\$20
Surgical extraction	\$120	\$120
<b>Orthodontia treatment</b>		
Pre-orthodontia services	\$150**	\$150**
Comprehensive orthodontic services	\$2,800***	\$2,800
<b>Miscellaneous</b>		
Local anesthesia	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Dental lab fees	Covered with the Office Visit Copay	Covered with the Office Visit Copay
Nitrous oxide	\$40	\$40
Specialty office visit	\$30	\$30
Out of area emergency care reimbursement	You pay charges in excess of \$100	You pay charges in excess of \$100

\*Limited to one dental implant surgery per calendar year.

\*\*Copayment credited towards the Comprehensive Orthodontic Service copayment if patient accepts treatment plan.

\*\*\*Copayment for Comprehensive Orthodontic Services provided for treatment of cleft palate with or without cleft lip is \$350 for members under age 19. Orthodontic Services for all other purposes are not included in the Annual Out of Pocket Limit.

## Can I sign up for the Direct Option Plan and still go to my own dentist?

To receive the excellent benefits of your Direct Option Plan you must receive care from a Willamette Dental Group dentist or specialist. Your coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental Group dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits.

## How do I schedule an appointment?

To schedule an appointment that meets your scheduling needs, please call the Willamette Dental Group Appointment Center:

Toll Free..... 1-855-4DENTAL (433-6825)

### Appointment Center Hours:

Monday – Friday 7 a.m. to 6 p.m. PT

Saturday 7 a.m. to 4 p.m. PT

## How long does it generally take to get an appointment?

The length of wait-time for an appointment may vary based on your choice of provider, dental office location, appointment type and your desired day or time of appointment. Willamette Dental Group's goal is to get you in within days or weeks to fit your lifestyle.

All of Willamette Dental Group's office locations practice the Simple Scheduling method. Through this model, more appointment types are offered everyday so you can be seen when it fits your schedule and needs.

## What can I expect at my first visit?

During your first visit to a Willamette Dental Group office, you will receive a thorough dental examination that includes X-rays and comprehensive risk assessments. Your dentist will develop a Proactive Dental Care Plan based upon your immediate needs, current dental health and long-term oral health goals. This individual plan will include recommendations for cleanings, restorations and preventive treatments. Most patients will receive a cleaning at their first visit, based on the assessment and recommendation from your dentist.

## Is orthodontia available at every office?

Specialty services, including orthodontia are generally available on a regional basis. To find out where specialty services are available in your area, simply contact the Willamette Dental Group Appointment Center toll free at (855) 433-6825.

## What if I have a dental emergency?

Willamette Dental Group provides emergency dental care during regular office hours. If you have a dental emergency, you should call the Appointment Center toll free at (855) 433-6825. If necessary, you will be scheduled to see a dentist within approximately 24 hours. After-hours, a dentist is available for dental emergency consultation over the telephone, at no cost.

## What if I have a dental emergency while I'm out of town?

If you are traveling 50 miles or more from a Willamette Dental Group office, you may obtain emergency treatment from any licensed dentist. Emergency dental treatment may be eligible for reimbursement up to the amount stated in your Member Handbook. Upon returning home, contact Willamette Dental Group's Member Services Department for reimbursement.

## What kind of training and experience do Willamette Dental Group dentists have?

All Willamette Dental Group dentists meet high standards for professional qualifications, licenses, endorsements, and certifications. Most have years of experience, and every dentist participates in the Willamette Dental Group Quality Assurance Program that includes regular peer reviews to ensure optimal care. Willamette Dental Group actively promotes professional development to continually enhance the capabilities of all Willamette Dental Group providers. Credentialing and information for all Willamette Dental Group providers, including patient ratings and comments, is available at [willamettedental.com](http://willamettedental.com).

## Can I get major work done right away?

The practice philosophy at Willamette Dental Group is to first diagnose and treat urgent conditions that pose an immediate threat to your oral health. The next priority is prevention; controlling the disease process. It is important that you be an active partner in maintaining good oral health to ensure the long-term success of the major restorative work you receive. Major restorative work is performed when your Willamette Dental Group dentist determines your teeth and supporting structures are stabilized, and when you have demonstrated a commitment to maintaining your oral health. This is the best way to ensure the long-term success of whatever major restorative work that you may need.

## How do I change an appointment?

If you need to reschedule or cancel an appointment, please call the Willamette Dental Group Appointment Center at (855) 433-6825 as soon as possible. Your provider may charge a missed appointment fee for any appointment that you miss without a minimum of 24 hours prior notice.

## Who do I call for more information?

Please direct questions about your dental plan or service to the Willamette Dental Group Member Services Department:

Monday – Friday .....8 a.m. to 5 p.m. PST

Phone ..... 1-855-4DENTAL (433-6825)

Email.....memberservices@willamettedental.com

*Please refer to your Member Handbook for limitations and exclusions.*