Janus Youth Programs, Inc.

Group #10006528

Dental Customer Service
503-265-2965 or 800-452-1058, dental@modahealth.com

Customer Service hours
Monday through Friday, 7:30 a.m. - 5:30 p.m. PST

modahealth.com
myModa dental

Be in charge of your healthy smile

Get to know your benefits! myModa, your personalized member website, helps you manage your dental plan and find ways to improve and maintain your oral health.

Discover more ways to better oral health

› Click on Find Care to find a dentist near you
› Get in touch with a dental health coach and find answers to your oral health questions
› Use the Dental Optimizer for a cavity risk assessment, treatment cost estimates and dental health tips
› Find dental care while travelling outside the U.S.

Easily see and manage your benefits

› View your benefit eligibility and history
› Receive and view electronic explanations of benefits (EOBs)
› View account information, such as your contact information and dependents
› Download your digital ID card or order a new one
› Check the status of pending claims, view your personal claims history and access claim forms

Log in to myModa 24/7

To sign in to myModa, visit modahealth.com. On the right-hand side of the home page, type in your username and password and click the Go! button.

If you don’t have a myModa account, creating one is easy. You’ll love everything you can do on myModa, like check your benefits, use interactive health tools, see your Member Handbook and more.

Questions?

We’re here to help. Call us toll-free at 888-374-8907. TTY users, please call 711.

Delta Dental of Oregon and Alaska

modahealth.com
# 2020 Delta Dental Premier Plan Benefit Summary

**Janus Youth Programs, Inc.**

Group ID: 10006528

<table>
<thead>
<tr>
<th>Premier Option B3X501</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar year costs</strong></td>
<td></td>
</tr>
<tr>
<td>Calendar year maximum, per member</td>
<td>$1,000</td>
</tr>
<tr>
<td>Calendar year deductible, per member</td>
<td>$50</td>
</tr>
<tr>
<td>Calendar year maximum deductible, per family</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Class 1</strong></td>
<td></td>
</tr>
<tr>
<td>Periodic examinations / X-rays</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylaxis (cleanings) / periodontal maintenance</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
</tr>
<tr>
<td>Topical application of fluoride</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Class 2</strong></td>
<td></td>
</tr>
<tr>
<td>Restorative fillings</td>
<td>80%</td>
</tr>
<tr>
<td>Oral surgery (extractions &amp; certain minor surgical procedures)</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (treatment of teeth with diseased or damaged nerves)</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics (treatment of diseases of the gums and supporting structures of the teeth)</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Class 3</strong></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
</tr>
<tr>
<td>Crowns and other cast restorations</td>
<td>50%</td>
</tr>
<tr>
<td>Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)</td>
<td>50%</td>
</tr>
</tbody>
</table>

* Deductible waived for preventive services.

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 him or her 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.
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 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.

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 nonsurgical 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 nonsurgical 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 anæsthesia (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.
Active&Fit Direct™ program

Stay active and fit for less

Staying fit is important to your overall health and well-being. Joining a fitness center can help you add more physical activity to your day.

Join a health club for just $25 a month!
As a Moda Health or Delta Dental member, you have access to the Active&Fit Direct™ program. For just $25 a month,* you can choose from over 9,000 participating health clubs and YMCAs nationwide.

The program offers:
- A free guest pass to try out a fitness center before joining
- An option to switch gyms to make sure you find the right fit
- Access to online directory maps and a health club locator from any device
- Online tracking from a variety of wearable fitness devices, apps and exercise equipment

Ready to join?
Log in to your myModa account at modadental.com. Select the Active&Fit Direct program link (under myHealth) to get started. Members should contact their gym of choice before signing up to see if there are any additional membership conditions or requirements.

*Initial enrollment is $75. This includes a sign-up fee and covers the first two months. A three-month commitment is required. Applicable taxes may apply.

Moda, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).
注意：如果您說中文，可撥打 免費語言幫助服務。請致電1-877-605-3229（聽障人士專用：711）

modahealth.com
Health through Oral Wellness®

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon’s Health through Oral Wellness® program offers extra benefits to members who have a greater risk for oral diseases.

The program uses an oral health assessment to find out your risk of tooth decay, gum disease and oral cancer. Based on your risk score, you may qualify for additional cleanings, fluoride treatments, sealants and periodontal maintenance.*

With extra benefits and related care, you can:
- Take charge of your oral health
- Prevent oral health issues before they happen
- Access resources to manage your oral health
- Learn how to achieve and maintain better oral wellness

Ready to get started?
Follow these simple steps to see if you qualify:

1. Visit deltadentalor.com/oralwellness/members to learn more about the program and take a free oral health risk self-assessment. You can choose to share your results with your dentist to start the conversation.

2. Talk to your dentist about the program. If they’re not registered, ask them to call our toll-free Health through Oral Wellness provider line at 844-663-4433. Once registered, they can perform an oral health risk exam and can let you know if you qualify.

Still have questions?
We’re here to help. Contact our Moda Employee Dental Customer Service Team at 503-412-4002.

* All enhanced dental benefits are subject to your plan’s annual maximum and other limitations. The enhanced benefits feature is available to Moda employee members working for our locations in Oregon.
MEMBER DASHBOARD

Be in charge of your healthy smile

Get to know your benefits! Your personalized member website, helps you manage your dental plan and find ways to improve and maintain your oral health

Discover more ways to better oral health
- Click on Find Care to find a dentist near you
- Get in touch with a dental health coach and find answers to your oral health questions
- Use the Dental Optimizer for a cavity risk assessment, treatment cost estimates and dental health tips
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- Download your digital ID card or order a new one
- Check the status of pending claims, view your personal claims history and access claim forms
Log in to your Member Dashboard 24/7
To sign in to your Member Dashboard, visit DeltaDental.com. On the top right side of the home page click the “sign in” button to get started.

If you don’t have an account, creating one is easy. You'll love everything you can do on your Member Dashboard, like check your benefits, use interactive health tools, see your Member Handbook and more.

Questions?
We’re here to help.
Call us toll-free at 844-663-4440.
TTY users, please call 711.
Enrollment application & change of information form
Dual Dental (1 – 99)

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed.

**Section 1 › Application type**

You’ll need a special enrollment reason for some changes made outside the open enrollment period. Special enrollment includes adding dependents to an existing plan and enrolling in the plan due to loss of other coverage. The reason I am applying or making a change is:

**Open enrollment**
- Date of event: _____ / _____ / _____
  - New policy/subscriber
  - Add dependent on existing plan
  - Plan change only
  - Waiver of coverage (see Section 7)

**Changes**
- Name change
  - New name: ______________________
  - Old name: ______________________
- New address
  (please write new address in Section 3)

**Special enrollment**
- Date of event: _____ / _____ / _____
  - Marriage
  - Registered domestic partner (RDP)
  - Birth, adoption or placement for adoption
  - Loss of coverage because I turned 26
  - Loss of coverage due to end of marriage or registered domestic partnership (RDP)
  - Involuntary loss of group coverage
  - COBRA/Continuation ended due to exhausting benefit
  - Other ______________________

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**Group name**
Janus Youth Programs, Inc.

**Subgroup**

**Group no.**
10006528

**Class**

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**Section 2 › Coverage**

- Dental coverage
- Delta Dental

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**Section 3 › Employee information**

<table>
<thead>
<tr>
<th>First name*</th>
<th>M.I.</th>
<th>Last name*</th>
<th>Social Security no.*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing address*</th>
<th>City*</th>
<th>State*</th>
<th>ZIP*</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home phone</th>
<th>Date of birth (mm/dd/yyyy)*</th>
<th>Gender*</th>
<th>Date of employment (mm/dd/yyyy)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary language</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>Spanish</td>
</tr>
</tbody>
</table>

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**Section 4 › Dependent eligibility information**

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- Your or your spouse’s natural or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian (you will need to attach a signed court order showing legal guardianship)
- Your domestic partner’s natural child or adopted child (if domestic partners by affidavit can enroll in your employer plan)
- Your registered domestic partner’s natural child or adopted child

*Enrollment will be delayed if fields with an asterisk are not filled out.

1 Please list only eligible dependent children.

See Section 4 for dependent children qualifications.
Section 5 › Dependents

Relationship code: SP = spouse, DP = domestic partner, RDP = registered domestic partner (DP and RDP only if applicable to your plan)
Please use additional form if needed.

<table>
<thead>
<tr>
<th>Add Term</th>
<th>Dependent first name*</th>
<th>Dependent last name*</th>
<th>Social Security no.*</th>
<th>Date of birth* (mm/dd/yyyy)</th>
<th>Gender*</th>
<th>Relationship*</th>
<th>Primary language (if different from employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M ☐ F</td>
<td>SP ☐ DP ☐ RDP</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M ☐ F</td>
<td>Child¹</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M ☐ F</td>
<td>Child¹</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M ☐ F</td>
<td>Child¹ ☐ Ward</td>
<td></td>
</tr>
</tbody>
</table>

Section 6 › Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No
If your Group’s size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group’s size is 20 employees or more, Medicare will be considered the secondary payer.

Section 7 › Waiver of coverage information

Please include the names of all eligible members who will NOT be enrolling. Please use additional form if needed.

<table>
<thead>
<tr>
<th>Person waiving</th>
<th>Reason for waiver</th>
<th>Health plan name</th>
<th>Policy no.</th>
<th>Employer group name</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Individual</td>
<td>☐ Employer group</td>
<td>☐ Medicare</td>
<td>☐ Other</td>
<td></td>
</tr>
<tr>
<td>☐ Individual</td>
<td>☐ Employer group</td>
<td>☐ Medicare</td>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

Section 8 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions. It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.

Employee signature* ☒ Signature date*
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)