



# OEGB Summary of Dental Benefits 2020-21 Plan Year

| Dental   | INCENTIVE PLANS<br><small>See footnote # for details.</small> |  |  | LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS!<br><small>See footnotes Q, †, and ‡ for details.</small> |   |   |
|--|---|--|--|--|---|---|
|  |   |  |  |  |   |   |
| Dental   | Premier Plan 1 †<br>Delta Dental Premier Network              | Premier Plan 5 †<br>Delta Dental Premier Network | Premier Plan 6<br>Delta Dental Premier Network | Exclusive PPO Plan <sup>Q</sup><br>Delta Dental PPO Network  | Kaiser Dental Plan <sup>†</sup><br>Kaiser Permanente Facilities | Willamette Dental Plan <sup>‡</sup><br>Willamette Dental Group Facilities |
| Dental Office Visit Copayment  | NA  | NA   | NA   | NA   | \$20 *  | \$20 <sup>4,5</sup>   |
| Benefit Maximum  | \$2,200   | \$1,700  | \$1,200  | \$1,500  | \$4,000 ***   | NA  |
| Deductible   | \$50  | \$50   | \$50   | \$50   | NA  | NA  |
| <b>Preventive &amp; Diagnostic Services * - Deductible Waived for Preventive &amp; Diagnostic Services on Delta Dental Plans</b> |   |  |  |  |   |   |
| Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers   | 70% + 10%<br>each Plan Year                                   | 70% + 10%<br>each Plan Year                      | 100%   | 100%   | 100% *  | 100% *  |
| <b>Restorative Services *</b>  |   |  |  |  |   |   |
| Routine fillings, inlays and stainless steel crowns  | 70% + 10% <sup>1</sup><br>each Plan Year                      | 70% + 10% <sup>1</sup><br>each Plan Year         | 80% <sup>1</sup>                               | 90% <sup>1</sup>   | 100% <sup>2</sup>   | 100% *  |
| <b>Simple Extraction *</b>   |   |  |  |  |   |   |
| Simple tooth extractions   | 70% + 10%<br>each Plan Year                                   | 70% + 10%<br>each Plan Year                      | 80%  | 90%  | 100% *  | 100% *  |
| <b>Oral Surgery *</b>  |   |  |  |  |   |   |
| Surgical tooth extractions, including diagnosis and evaluation   | 70% + 10%<br>each Plan Year                                   | 70% + 10%<br>each Plan Year                      | 80%  | 90%  | \$50 Copay *  | \$50 Copay *  |
| <b>Periodontics *</b>  |   |  |  |  |   |   |
| Diagnosis, evaluation, and treatment of gum disease including scaling and root planing   | 70% + 10%<br>each Plan Year                                   | 70% + 10%<br>each Plan Year                      | 80%  | 90%  | 100% *  | 100% *  |
| <b>Endodontics *</b>   |   |  |  |  |   |   |
| Root canal and related therapy including diagnosis and evaluation  | 70% + 10%<br>each Plan Year                                   | 70% + 10%<br>each Plan Year                      | 80%  | 90%  | \$50 Copay *  | \$50 Copay *  |
| <b>Major Restorative Services *</b>  |   |  |  |  |   |   |
| Gold or porcelain crowns and onlays  | 70% + 10%<br>each Plan Year                                   | 70%  | 50%  | 80%  | \$250 Copay *   | \$250 Copay <sup>4,5</sup>  |
| Implants   | 70% + 10%<br>each Plan Year                                   | 50%  | 50%  | 80%  | 50% *<br>(limit of 4 per lifetime)                              | Implant surgery up to \$1,500<br>calendar year maximum                    |
| <b>Other covered services*</b>   |   |  |  |  |   |   |
| Occlusal guards (night guards)   | 50% up to \$250 max,<br>once every 5 years                    | 50% up to \$250 max,<br>once every 5 years       | 50% up to \$250 max,<br>once every 5 years     | 50% up to \$250 max,<br>once every 5 years   | 90%   | 100% <sup>4</sup>   |
| Athletic mouth guards  | 50%   | 50%  | 50%  | 50%  | 90%   | \$100 Copay *   |
| Nitrous Oxide  | 50%   | 50%  | 50%  | 50%  | \$25 Copay * (Ages 13 & Up)                                     | \$15 Copay *  |
| <b>Fixed and Removable Prosthetic Services *</b>   |   |  |  |  |   |   |
| Full and partial dentures, relines, rebases  | 70% + 10%<br>each Plan Year                                   | 50%  | 50%  | 80%  | \$100 Copay *   | \$100 Copay <sup>4,5</sup>  |
| Bridge retainers and pontics   | 70% + 10%<br>each Plan Year                                   | 50%  | 50%  | 80%  | \$250 Copay *   | \$250 Copay <sup>4,5</sup>  |
| <b>Orthodontics * (All plans except Delta Dental Plan 6)</b>   |   |  |  |  |   |   |
| Orthodontic Treatment  | 80% to \$1,800<br>lifetime max                                | 80% to \$1,800<br>lifetime max                   | <b>NO ORTHO COVERAGE<br/>on this plan</b>      | 80% to \$1,800<br>lifetime max   | \$2,500 Copay +<br>\$20 per visit **                            | \$2,500 Copay +<br>\$20 per visit **                                      |

# Under Delta Dental Plans 1 and 5, benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year. Switching between incentive plans (1 or 5) and other non-incentive plans will have an effect on benefit level.

Q The Delta Dental Exclusive PPO plan has no out-of-network benefit. Services performed by providers outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and x-rays. All other services are considered non-covered.

† The Kaiser Dental Plan does NOT require enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.

‡ Under the Willamette Dental Plan, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.

\* For Kaiser Permanente and Willamette Dental Group plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.

\*\* Pre-Orthodontic Service fee of \$150 is credited toward the orthodontic benefit if patient accepts treatment plan.

\*\*\* Preventive care and orthodontia do not accrue to this maximum.

<sup>1</sup> Amalgam and composite filling are covered.

<sup>2</sup> Fillings are covered at 100% for all amalgam on posterior teeth, composite on anterior (smile line). Patients can request composite fillings, which are considered a buy-up and additional fees apply. Contact Kaiser Permanente directly for fees

<sup>3</sup> The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.

<sup>4</sup> Replacement of lost or stolen appliance once every 2 years; replacement or repair of broken appliance as needed.

<sup>5</sup> Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

This document is for comparison purposes only and is not intended to fully describe the benefits of each Plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.