



Summary of Dental Benefits 2016-17 Plan Year

| | DELTA DENTAL | DELTA DENTAL | DELTA DENTAL | DELTA DENTAL | DELTA DENTAL | KAISER PERMANENTE | Willamette Dental Group |
|--|--|--|--|--|--|--|--|
| Dental | Dental Plan 1 † | Dental Plan 2 † | Dental Plan 3 † | Dental Plan 4 | Dental Plan 6 | Dental Plan 8 † | Dental Plan 8 ‡ |
| Dental Office Visit Copayment | NA | NA | NA | NA | NA | \$20 * | \$20 ** |
| Benefit Maximum | \$2,200 | \$1,500 | \$1,500 | \$1,500 | \$1,200 | \$4,000 *** | NA |
| Deductible | \$50 | \$50 | \$50 | \$50 | \$50 | NA | NA |
| Preventive and Diagnostic Services * - Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans | | | | | | | |
| Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 100% | 100% | 100% * | 100% * |
| Restorative Services * | | | | | | | |
| Routine fillings, inlays and stainless steel crowns | 70% + 10% ¹ each Plan Year | 70% + 10% ¹ each Plan Year | 70% + 10% ¹ each Plan Year | 80% ¹ | 80% ¹ | 100% ^{2*} | 100% ^{2*} |
| Simple Extraction * | | | | | | | |
| Simple tooth extractions | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 80% | 100% * | 100% * |
| Oral Surgery * | | | | | | | |
| Surgical tooth extractions, including diagnosis and evaluation | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 80% | 100% * | 100% * |
| Periodontics * | | | | | | | |
| Diagnosis, evaluation, and treatment of gum disease including scaling and root planing | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 80% | 100% * | 100% * |
| Endodontics * | | | | | | | |
| Root canal and related therapy including diagnosis and evaluation | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 80% | 100% * | 100% * |
| Major Restorative Services * | | | | | | | |
| Gold or porcelain crowns and onlays | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 50% | 100% * | 100% * |
| Implants | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 50% | 50% | 50% | 50% * (limit of 4 per lifetime) | See Certificate of Coverage for copays |
| Occlusal guards (night guards) | 50% up to \$150 maximum, once every 5 years | 50% up to \$150 maximum, once every 5 years | 50% up to \$150 maximum, once every 5 years | 50% up to \$150 maximum, once every 5 years | 50% up to \$150 maximum, once every 5 years | 50% up to \$150 maximum, once every 5 years | 100% ⁴ |
| Fixed and Removable Prosthetic Services * | | | | | | | |
| Full and partial dentures, relines, rebases | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 50% | 50% | 50% | 100% * | 100% * |
| Bridge retainers and pontics | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 50% | 50% | 50% | 100% * | 100% * |
| Orthodontics * (All plans except Delta Dental Plan 6) | | | | | | | |
| Orthodontic Treatment | 80% to \$1,800 lifetime max | 80% to \$1,800 lifetime max | 80% to \$1,800 lifetime max | 80% to \$1,800 lifetime max | NA | \$1,500 copay + \$20 per visit | \$1,500 copay + \$20 per visit ** |

♦ Under Delta Dental Plans 1-3 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 - 3) and non-incentive plans (4, 6 and 8) will have an effect on benefit level.

† Kaiser Dental Plan 8 no longer requires 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 Willamette Dental Group Plan 8, 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.

*** Preventative care and orthodontia do not accrue to this maximum

¹ Posterior fillings paid to amalgam fee.

² Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser Permanente or Willamette Dental Group directly for actual fees.

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

⁴ Replacement of lost or stolen appliance once every 2 years, replacement or repair of broken appliance as needed.

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.