OEBB Summary of Dental Benefits 2018-19 Plan Year

Dental	Premier Plan 5♦ Delta Dental Premier Network	Premier Plan 6 Delta Dental Premier Network	LIMITED NETWORK PLANS- MUST USE IN-NETWORK PROVIDERS! Willamette Dental Plan‡ Willamette Dental Group Facilities
Dental Office Visit Copayment	NA	NA	$20 [3]*
Benefit Maximum	$1,700	$1,200	NA
Deductible	$50	$50	NA
Preventive & 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	100%	100% *
Restorative Services *			
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	80% [1]	100% *
Simple Extraction *			
Simple tooth extractions	70% + 10% each Plan Year	80%	100% *
Oral Surgery *			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay *
Periodontics *			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	80%	100% *
Endodontics *			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay*
Major Restorative Services *			
Gold or porcelain crowns and onlays	70%	50%	$250 Copay *
Implants	50%	50%	See Certificate of Coverage for copays
Other covered services*			
Occlusal guards (night guards)	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	100% [4]
Athletic mouth guards	50%	50%	$100 Copay *
Nitrous Oxide	50%	50%	$15 Copay *
Fixed and Removable Prosthetic Services *			
Full and partial dentures, relines, rebases	50%	50%	$100 Copay *
Bridge retainers and pontics	50%	50%	$250 Copay *
Orthodontics * (All plans except Delta Dental Plan 6)			
Orthodontic Treatment	80% to $1,800 lifetime max	NA	$2,500 Copay + $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.

‡ 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.
[1] Posterior fillings paid to composite 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
[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.

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