OEBB Summary of Dental Benefits 2020-21 Plan Year

	INCENTIVE PLANS See footnote ♦ for details.			LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS! See footnotes Ω, †, and ‡ for details.		
	DELTA DENTAL moda	DELTA DENTAL moda	DELTA DENTAL moda		KAISER PERMANENTE	Willamette Dental Group
Dental	**Premier Plan 1 ♦ Delta Dental Premier Network**	**Premier Plan 5 ♦ Delta Dental Premier Network**	**Premier Plan 6 Delta Dental Premier Network**		**Kaiser Dental Plan† Kaiser Permanente Facilities**	**Willamette Dental Plan‡ Willamette Dental Group Facilities**
Dental Office Visit Copayment	NA	NA	NA		$20 *	$20 *[3]
Benefit Maximum	$2,200	$1,700	$1,200		$4,000 ***	NA
Deductible	$50	$50	$50		NA	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	70% + 10% each Plan Year	100%		100% *	100% *
Restorative Services *						
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year	80% [1]		100% *[2]	100% *
Simple Extraction *						
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		100% *	100% *
Oral Surgery *						
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		$50 Copay *	$50 Copay *
Periodontics *						
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		100% *	100% *
Endodontics *						
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		$50 Copay *	$50 Copay *
Major Restorative Services *						
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%		$250 Copay *	$250 Copay *[5]
Implants	70% + 10% each Plan Year	50%	50%		50% * (limit of 4 per lifetime)	Implant surgery up to $1,500 calendar year maximum
Other covered services*						
Occlusal guards (night guards)	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years		90%	100% [4]
Athletic mouth guards	50%	50%	50%		90%	$100 Copay *
Nitrous Oxide	50%	50%	50%		$25 Copay * (Ages 13 & Up)	$15 Copay *
Fixed and Removable Prosthetic Services *						
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%		$100 Copay *	$100 Copay *[5]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%		$250 Copay *	$250 Copay *[5]
Orthodontics * (All plans except Delta Dental Plan 6)						
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	**NO ORTHO COVERAGE on this plan**		$2,500 Copay + $20 per visit **	$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.

Ω 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.

[1] Amalgam and composite filling are covered.

[2] 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

[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.

[5] 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.

OEBB Summary of Vision Benefits 2020-21 Plan Year

Vision	Kaiser Vision Plan** Kaiser Permanente Facilities	Moda Opal Plan May use any licensed provider		Moda Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	
Plan Year Maximum	$250	$600*		$250*	N/A	
Routine Eye Exam:						
Benefit:	Covered under the Kaiser Permanente medical plan	Plan pays 100% (up to plan maximum)		Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	
Frequency:	As needed	Once per Plan Year		Once per Plan Year	Once every 12 months	
Lenses:						
Basic lens benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)		Plan pays 100% (up to plan maximum)	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Polycarbonate lenses, scratch resistant and UV coatings covered in full**	
Lens enhancements:					$0 copay for standard progressive lenses **$15 copay for anti-reflective coating or premium/custom progressive lenses**	
Frequency:	Once per Plan Year	Once per Plan Year		Once per Plan Year	Once every 12 months	
Frames / Contacts:						
Benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)		Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300**; 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.	
Frequency:	Once per Plan Year	**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year		**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	Once every 12 months	
Non-Prescription Benefit						
Benefit:	$100 of your annual $250 allowance may be used toward non-prescription sunglasses and/or digital eye strain glasses.	Not Covered		Not Covered	OEBB members can use their frame allowance to pay for non-prescription sunglasses, in lieu of prescription glasses or contacts. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details	

*Exam and hardware charges all apply to the plan year maximum on Moda Plans

**Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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v1 4-6-2020