

Hillsboro School District Summary of **Dental** Benefits 2022-23 Plan Year

	Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Kaiser Dental Plan	Willamette Dental Plan
	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Limited Network Plan – Kaiser Permanente Facilities ²	Limited Network Plan – Willamette Dental Group Facilities ²
Dental Office Visit Copayment	N/A	N/A	N/A	\$20 ³	\$20 ³
Benefit Maximum	\$2,200 ⁴	\$1,700 ⁴	\$1,200	\$4,000 ⁴	N/A
Deductible	\$50	\$50	\$50	N/A	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans⁶					
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year ⁶	70% + 10% each Plan Year ⁶	100% ⁶	100% ⁶	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% ³	100% ³
Simple Extraction					
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	100% ³	100% ³
Oral Surgery					
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	\$50 Copay ³	\$50 Copay ³
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% ³	100% ³
Endodontics					
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	\$50 Copay ³	\$50 Copay ³
Major Restorative Services					
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	\$250 Copay ³	\$250 Copay ³
Implants	70% + 10% each Plan Year	50%	50%	50% ³ (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%, once every 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	90%	\$100 Copay ³
Nitrous Oxide	50%	50%	50%	\$0 copay (Age 12 & Under) \$25 copay (Age 13 & Up)	\$15 Copay ³
Fixed and Removable Prosthetic Services					
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	\$100 Copay ³	\$100 Copay ³
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	\$250 Copay ³	\$250 Copay ³
Orthodontics					
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

¹ Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan 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.

² Services performed by providers outside the limited network are not covered unless for a dental emergency.

³ Office visit copayment applies at each visit, in addition to any plan copayments for services.

⁴ Preventive care and orthodontia do not accrue to this maximum.

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

⁶ Preventive services will not accrue towards the plan benefit maximum.

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.

Hillsboro School District Summary of **Vision** Benefits 2022-23 Plan Year

Dental	Kaiser Vision Plan ¹ 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 (does not apply to the vision plan year maximum)	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	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:	Age 19+: Plan pays 100% (up to plan maximum)			
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
Frequency:	Frames or Contacts: Once per Plan Year	Frames: Age 0-16: Once per Plan Year Age 17+: Once every two Plan Years or Contacts: Up to the plan maximum	Frames: Age 0-16: Once per Plan Year Age 17+: Once every two Plan Years or Contacts: Up to the plan maximum	Frames or Contacts: 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 ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.

¹ Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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You can get this document in other languages, large print, braille or a format you prefer. Contact OEBB Member Services at 888-4My-OEBB (888-469-6322) or email oebb.benefits@state.or.us. We accept all relay calls or you can dial 711.