Summary of Dental Benefits 2021-22 Plan Year

	INCENTIVE PLANS See footnote ♦ for details.		DELTA DENTAL Delta Dental of Oregon & Alask moda HEALTH	LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS! See footnotes Ω, †, and ‡ for details.			
	DELTA DENTAL Delta Dental of Oregon & Alask	moda HEALTH		DELTA DENTAL Delta Dental of Oregon & Alask	moda HEALTH	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**	**Exclusive PPO – Incentive Plan Ω ♦ Delta Dental PPO Network**	**Exclusive PPO Plan Ω Delta Dental PPO Network**	**Kaiser Dental Plan† Kaiser Permanente Facilities**	**Willamette Dental Plan‡ Willamette Dental Group Facilities**
Dental Office Visit Copayment	NA	NA	NA	NA	NA	$20 *	$20*[3]
Benefit Maximum	$2,200	$1,700	$1,200	$2,300	$1,500	$4,000 ***	NA
Deductible	$50	$50	$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%	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]	70% + 10%[1] each Plan Year	90%[1]	100%*[2]	100% *
Simple Extraction *							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%*	100% *
Oral Surgery *							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$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%	70% + 10% each Plan Year	90%	100%*	100% *
Endodontics *							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay*	$50 Copay *
Major Restorative Services *							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	70% + 10% each Plan Year	80%	$250 Copay*	$250 Copay*[5]
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	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	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%	50%	50%	90%	$100 Copay *
Nitrous Oxide	50%	50%	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%	70% + 10% each Plan Year	80%	$100 Copay*	$100 Copay*[5]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$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	80% to $1,800 lifetime max	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit **	$2,500 Copay + $20 per visit **

♦ 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. Switching between incentive plans (1,5, or Exclusive PPO - Incentive Plan) and other non-incentive plans will have an effect on benefit level.

Ω The Delta Dental Exclusive PPO plan and Exclusive PPO - Incentive 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 (KP) and Willamette Dental Group (WDG) plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.
KP Plan Only: $0 office visit copay for preventive office visit.
WDG Plan Only: Office visit copay waived for new patient visit for members who have never seen a WDG provider.

** 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.