2017-2018 INSURANCE PLAN OFFERINGS

FOR QUESTIONS/INFORMATION REGARDING ALL PLANS, PLEASE CONTACT THE FOLLOWING:

MODA MEDICAL & VISION PLANS: **1-866-923-0409** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

VSP VISION PLANS: **1-800-877-7195** **Website**: www.vsp.com

MODA DENTAL PLANS: **1-866-923-0410** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

WILLAMETTE DENTAL PLANS: **1-855-433-6825** **Website**: www.willamettedental.com/oebb **Email**: info@willamettedental.com

MODA PHARMACY PLANS: **1-866-923-0411** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

UNUM LONG-TERM CARE PLANS: **1-800-227-4165** **Website**:unuminfo.com/OEBB002/index.aspx

THE STANDARD LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT, SHORT-TERM DISABILITY & LONG-TERM DISABILITY PLANS:

Phone: **1-866-756-8115** **Website**: www.standard.com/mybenefits/oebb

Summary of Medical and Pharmacy Benefits
2017-18 Plan Year

No lifetime maximum on any medical plans.	moda HEALTH **Alder CCM** Synergy or Summit Network**		moda HEALTH **Birch CCM** Synergy or Summit Network**		moda HEALTH **Cedar CCM** Synergy or Summit Network**		moda HEALTH **Dogwood CCM** Synergy or Summit Network**		moda HEALTH **Evergreen CCM** Synergy or Summit Network** *HSA Required*	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$400	$800	$800	$1,600	$1,200	$2,400	$1,600	$3,200	$1,600[2]	$3,200[2]
Maximum deductible per family	$1,200	$2,400	$2,400	$4,800	$3,600	$7,200	$4,800	$9,600	$3,200[2]	$6400[2]
Out-of-pocket (OOP) maximum per person [3]	$3,000	$6,000	$4,000	$8,000	$5,000	$10,000	$6,850	$13,700	$6,550[2]	$13,100[2]
Out-of-pocket (OOP) maximum per family [3]	$9,000	$18,000	$12,000	$24,000	$13,700	$27,400	$13,700	$27,400	$13,100[2]	$26,200[2]
Maximum cost share per person	$6,850	N/A	$6,850	N/A	$6,850	N/A	$6,850	N/A	NA	NA
Maximum cost share per family	$13,700	N/A	$13,700	N/A	$13,700	N/A	$13,700	N/A	NA	NA
Preventive Care Services										
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)										
Moda Medical Home incentive care	$10 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	20%	50%
Incentive office visits and home visits	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%
Office Services										
Moda Medical Home primary care services	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Primary care office visits	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%
Specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50[1]		$50[1]		$50[1]		$50[1]		20%	
Mental Health Services										
Mental health office visits	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	20%	50%
Outpatient Services										
Outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Tests (outpatient)										
Preventive tests	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Laboratory	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
CT, MRI, PET scans	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Alternative Care Services ($2,000 combined maximum)										
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Maternity Care										
Outpatient Materntity Care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Hospital Services										
Inpatient care/surgery	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%

Summary of Medical and Pharmacy Benefits
2017-18 Plan Year

No lifetime maximum on any medical plans.	Alder CCM** Synergy or Summit Network		Birch CCM** Synergy or Summit Network		Cedar CCM** Synergy or Summit Network		Dogwood CCM** Synergy or Summit Network		Evergreen CCM** Synergy or Summit Network *HSA Required*	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Additional Cost Tier										
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	20%	50%
Emergency Services										
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%	
Ambulance	20%		20%		20%		20%		20%	
Other Covered Services										
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	50%	10%	50%	10%	50%	10%	50%	20%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered
Pharmacy Services										
Out-of-pocket Maximum	Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max	
Retail										
Value (Moda Plans Only)	$0		$0		$0		$0		$0[1]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$8 per 31-day supply		$8 per 31-day supply		$8 per 31-day supply		$8 per 31-day supply		20%	
Preferred Brand	25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		20%	
Non-preferred brand	50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		20%	
Mail										
Value (Moda Plans Only)	$0		$0		$0		$0		$0[1]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$16 per 90-day supply		$16 per 90-day supply		$16 per 90-day supply		$16 per 90-day supply		20%	
Preferred Brand	25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		20%	
Non-preferred brand	50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		20%	
Specialty										
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		20%	
Non-preferred brand	50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		20%	

N/A - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level.

[1] Deductible waived.

[2] Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

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.

Summary of Medical and Pharmacy Benefits
2017-18 Plan Year

No lifetime maximum on any medical plans.	moda HEALTH **Birch PPO Connexus Network**		moda HEALTH **Cedar PPO Connexus Network**		moda HEALTH **Dogwood PPO Connexus Network**		moda HEALTH **Evergreen PPO Connexus Network** *HSA Required*	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$800	$1,600	$1,200	$2,400	$1,600	$3,200	$1,600[2]	$3,200[2]
Maximum deductible per family	$2,400	$4,800	$3,600	$7,200	$4,800	$9,600	$3,200[2]	$6400[2]
Out-of-pocket (OOP) maximum per person [3]	$4,000	$8,000	$5,000	$10,000	$6,850	$13,700	$6,550[2]	$13,100[2]
Out-of-pocket (OOP) maximum per family [3]	$12,000	$24,000	$13,700	$27,400	$13,700	$27,400	$13,100[2]	$26,200[2]
Maximum cost share per person	$6,850	N/A	$6,850	N/A	$6,850	N/A	NA	NA
Maximum cost share per family	$13,700	N/A	$13,700	N/A	$13,700	N/A	NA	NA
Preventive Care Services								
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)								
Moda Medical Home incentive care	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	20%	50%
Incentive office visits and home visits	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%	50%
Office Services								
Moda Medical Home primary care services	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Primary care office visits	20%	50%	20%	50%	20%	50%	20%	50%
Specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50[1]		$50[1]		$50[1]		20%	
Mental Health Services								
Mental health office visits	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	50%	$0[1]	50%	20%	50%
Outpatient Services								
Outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	20%	50%	20%	50%	20%	50%	20%	50%
Tests (outpatient)								
Preventive tests	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Laboratory	20%	50%	20%	50%	20%	50%	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%	20%	50%	20%	50%	20%	50%
CT, MRI, PET scans	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Alternative Care Services ($2,000 combined maximum)								
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	20%	50%	20%	50%	20%	50%	20%	50%
Maternity Care								
Outpatient Materntity Care	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%	20%	50%	20%	50%
Hospital Services								
Inpatient care/surgery	20%	50%	20%	50%	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	50%	20%	50%	20%	50%

Summary of Medical and Pharmacy Benefits
2017-18 Plan Year

No lifetime maximum on any medical plans.	Birch PPO Connexus Network		Cedar PPO Connexus Network		Dogwood PPO Connexus Network		Evergreen PPO Connexus Network *HSA Required*	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Additional Cost Tier								
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	20%	50%
Emergency Services								
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%	
Ambulance	20%		20%		20%		20%	
Other Covered Services								
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	50%	10%	50%	10%	50%	20%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered
Pharmacy Services								
Out-of-pocket Maximum	Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward plan OOP max	
Retail								
Value (Moda Plans Only)	$4 per 31-day supply		$4 per 31-day supply		$4 per 31-day supply		$4 per 31-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$12 per 31-day supply		$12 per 31-day supply		$12 per 31-day supply		20%	
Preferred Brand	25% up to $75 per 31-day supply		25% up to $75 per 31-day supply		25% up to $75 per 31-day supply		20%	
Non-preferred brand	50% up to $175 per 31-day supply		50% up to $175 per 31-day supply		50% up to $175 per 31-day supply		20%	
Mail								
Value (Moda Plans Only)	$8 per 90-day supply		$8 per 90-day supply		$8 per 90-day supply		$8[1] per 90-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$24 per 90-day supply		$24 per 90-day supply		$24 per 90-day supply		20%	
Preferred Brand	25% up to $150 per 90-day supply		25% up to $150 per 90-day supply		25% up to $150 per 90-day supply		20%	
Non-preferred brand	50% up to $450 per 90-day supply		50% up to $450 per 90-day supply		50% up to $450 per 90-day supply		20%	
Specialty								
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply		25% up to $200 per 31-day supply		25% up to $200 per 31-day supply		20%	
Non-preferred brand	50% up to $500 per 31-day supply		50% up to $500 per 31-day supply		50% up to $500 per 31-day supply		20%	

N/A - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level.

[1] Deductible waived.

[2] Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

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.

Summary of Vision Benefits
2017-18 Plan Year

Vision	Kaiser Vision Plan** Kaiser Permanente Facilities	Opal Plan May use any licensed provider	Pearl Plan May use any licensed provider	Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	VSP Choice Plan VSP Choice Network
					NEW for 2017-18	NEW for 2017-18
Plan Year Maximum		$600*	$400*	$250*	N/A	N/A
Routine Eye Exam:						
Benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Every 12 months	Every 12 months
Lenses:						
Basic lens benefit:		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**	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Scratch resistant and UV coatings covered in full**
Lens enhancements					**$15 copay for anti-reflective coating or progressive lenses**	Discounts for polycarbonate, anti-reflective coating or progressive lenses
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:		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	Covered in full up to retail allowance of **$150**; 20% off amount over retail allowance for frames
Frequency:		**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	**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	Once every 12 months	Once every 12 months

*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

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.

Summary of Dental Benefits
2017-18 Plan Year

Dental	Premier Plan 1 ♦ Delta Dental Premier Network	Premier Plan 5♦ Delta Dental Premier Network NEW for 2017-18	Premier Plan 6 Delta Dental Premier Network		Exclusive PPO Plan[Ω] Delta Dental PPO Network NEW for 2017-18	Kaiser Dental Plan[†] Kaiser Permanente Facilities	Willamette Dental Plan[‡] Willamette Dental Group Facilities
Dental Office Visit Copayment	NA	NA	NA		NA		$20 [3]*
Benefit Maximum	$2,200	$1,700	$1,200		$1,500		NA
Deductible	$50	$50	$50		$50		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	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]		90% [1]		100% *
Simple Extraction *							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		90%		100% *
Oral Surgery *							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		90%		100% *
Periodontics *							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		90%		100% *
Endodontics *							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%		90%		100% *
Major Restorative Services *							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%		80%		100% *
Implants	70% + 10% each Plan Year	50%	50%		80%		See Certificate of Coverage for copays
Other covered services*							
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		100% [4]
Athletic mouth guards	50%	50%	50%		50%		$100*
Fixed and Removable Prosthetic Services *							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%		80%		100% *
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%		80%		100% *
Orthodontics * (All plans except Delta Dental Plan 6)							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NA		80% to $1,800 lifetime max		$1,500 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.

† 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.

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.

* 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 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 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.