

## Summary of Dental Benefits for 2023-2024 Plan Year

Plan Option	Kaiser Dental Plan 8 <sup>+,2</sup>	Delta Dental Premier Plan 1 <sup>1</sup>	Delta Dental <sup>Ω, 2</sup> Exclusive PPO NETWORK	Willamette Dental Plan 8 <sup>±,2</sup>
Dental Office Visit Copayment	\$20 <sup>3</sup>	N/A	N/A	\$20 <sup>3,*</sup>
Benefit Maximum	\$4,000 <sup>4</sup>	\$2,200 <sup>4</sup>	\$1,500 <sup>4</sup>	N/A
Deductible	N/A	\$50	\$50	N/A
<b>Preventive and Diagnostic Services<sup>6</sup> (Deductible waived on Delta Dental plans)</b>				
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	100% <sup>6</sup> (does not accrue towards plan benefit max)	70% + 10% each Plan Year <sup>6</sup> (does not accrue towards plan benefit max)	100% <sup>6</sup> (does not accrue towards plan benefit max)	100% <sup>*</sup>
<b>Restorative Services</b>				
Routine fillings, inlays & stainless steel crowns	100% <sup>3</sup>	70% + 10% <sup>1</sup> each Plan Year	90% <sup>1</sup>	100% <sup>3</sup>
<b>Simple Extraction</b>				
Simple tooth extractions	100% <sup>3</sup>	70% + 10% each Plan Year	90%	100% <sup>3</sup>
<b>Oral Surgery</b>				
Surgical tooth extractions, including diagnosis and evaluation	\$50 copay <sup>3</sup>	70% + 10% each Plan Year	90%	\$50 copay <sup>3</sup>
<b>Periodontics</b>				
Diagnosis, evaluation, and treatment of gum disease including scaling and root planning	100% <sup>3</sup>	70% + 10% each Plan Year	90%	100% <sup>3</sup>
<b>Endodontics</b>				
Root canal and related therapy including diagnosis and evaluation	\$50 copay <sup>3</sup>	70% + 10% each Plan Year	90%	\$50 copay <sup>3</sup>
<b>Major Restorative Services</b>				
Gold or porcelain crowns and onlays	\$250 copay <sup>3</sup>	70% + 10% each Plan Year	80%	\$250 copay <sup>3,5</sup>
Implants	50%* (limit of 4 per lifetime)	70% + 10% each Plan Year	80%	Implant surgery up to \$1,500 calendar year max <sup>5</sup>
<b>Other Covered Services</b>				
Occlusal guards (night guards)	90%, once every 5 years	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	100%, once every 2 years
Athletic mouth guards	90%	50%	50%	\$100 copay <sup>3</sup>
Nitrous Oxide	\$25 (age 13 & up)	50%	50%	\$15 copay <sup>3</sup>
Full and partial dentures, relines, rebases	\$100 copay <sup>3</sup>	70% + 10% each Plan Year	80%	\$100 copay <sup>3,5</sup>
Bridge retainers and pontics	\$250 copay <sup>3</sup>	70% + 10% each Plan Year	80%	\$250 copay <sup>3,5</sup>
Orthodontic Treatment	\$2,500 copay + \$20 per visit	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	\$2,500 copay + \$20 per visit

Plan Premium	Kaiser Dental	Delta Dental Premier Plan 1	Delta Exclusive PPO	Willamette Dental
Employee Only	\$70.88	\$65.61	\$38.33	\$46.99
Employee + Spouse/Partner	\$155.96	\$129.99	\$75.92	\$93.99
Employee + Child(ren)	\$134.69	\$144.54	\$84.43	\$100.11
Employee + Family	\$219.74	\$214.06	\$125.05	\$150.18

The premiums listed above are not the amounts that you pay each month. Utilize the Monthly Benefits Calculator on the [HR Webpage](#) to calculate your monthly out-of-pocket cost.

- 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.
- 1 Under Delta Dental Plan 1, 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 and other non-incentive plans will have an effect on benefit level.  
Amalgam and composite filling are covered.
- 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 handbook will prevail.**