

## **Section 3: Dental Benefits**

### ***Dental Plan Options***

Each of PEBB's dental plans provides a member handbook (also called certificate or evidence of coverage). They are incorporated in this Summary Plan Description by reference here and are available for download as printable documents on PEBB's Web site. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's healthcare needs.

PEBB sponsors three types of dental plan designs: a traditional plan design offered by Kaiser Permanente and ODS, a preferred provider dental plan design from ODS, and a dental health maintenance organization plan design from Willamette Dental.

You may enroll different eligible dependents in your dental plan than are enrolled in your medical plan.

**Kaiser Permanente Traditional Plan Design.** You may enroll in this plan if you live or work (at least 50 percent of the time) in the Kaiser service area (refer to the plan's evidence of coverage). The plan covers services only from Kaiser Permanente providers in Kaiser facilities. You do not have to be enrolled in the Kaiser medical plan to enroll in the Kaiser dental plan.

Following are the Benefit Summaries for the Kaiser Permanente dental plans.

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## Kaiser Permanente Dental Full-time Benefit Summary

This Benefit Summary, which is part of the Evidence of Coverage (EOC), is a summary of answers to the most frequently asked questions about benefits. This chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits” and “Exclusions and Limitations” sections of this Evidence of Coverage, which is listed in the same order as in the “Benefit Summary.” Exclusions and limitations that apply to all benefits are described in the “Exclusions and Limitations” section of this Evidence of Coverage.

Some works-in-progress may be reduced to a 50% payment of the Usual and Customary Charges. Please refer to the “Exclusions and Limitations” section of the Evidence of Coverage for details.

<b>Benefit</b>	<b>You Pay</b>
<b>Dental Office Visit Charge</b>	\$0
<b>Benefit Maximum</b>	\$1,750
<b>Preventive and Diagnostic Services</b>	<b>You Pay</b>
Oral Exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
<b>Basic Restorative Services</b>	<b>You Pay</b>
Routine fillings	20%
Crowns (plastic/acrylic and steel)	20%
Simple extractions	20%
<b>Oral Surgery</b>	<b>You Pay</b>
Surgical tooth extractions including diagnosis and evaluation	20%
Major Oral Surgery	20%
<b>Periodontics</b>	<b>You Pay</b>
Diagnosis and evaluation	20%
Treatment of gum disease	20%
Scaling and root planing	20%
Periodontal Maintenance (Current Dental Terminology Code 4910)	No additional charge
<b>Endodontics</b>	<b>You Pay</b>
Root canal, related therapy, including diagnosis and evaluation	20%
<b>Major Restoration Services</b>	<b>You Pay</b>

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Gold or porcelain crowns	25%
Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	50% up to Benefit Maximum
<b>Removable Prosthetic Services</b>	<b>You Pay</b>
Full and partial dentures	50%
Relines	50%
Rebases	50%
<b>Emergency Care</b>	<b>You Pay</b>
From Dental Group Providers	\$25 for Emergency and Urgent Care visits on the same or next business day plus any other Charges that normally apply.
From non-Dental Group providers	All Charges over \$100
<b>Other Benefits</b>	<b>You Pay</b>
Nightguards	10%
Nitrous oxide	
Adults and children age 13 years and older	\$15.00
Children age 12 years and younger	No Charge
<b>Questions? Call Membership Services (M-F, 8am – 6pm)</b>	
Portland: 503-813-2000, outside Portland: 1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010	
This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.	

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## Kaiser Permanente Dental Part-time and Retiree Benefit Summary

This Benefit Summary, which is part of this Evidence of Coverage (EOC), is a summary of answers to the most frequently asked questions about benefits. This chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits” and “Exclusions and Limitations” sections of this Evidence of Coverage, which is listed in the same order as in the “Benefit Summary.” Exclusions and limitations that apply to all benefits are described in the “Exclusions and Limitations” section of this Evidence of Coverage.

Some works-in-progress may be reduced to a 50% payment of the Usual and Customary Charges. Please refer to the “Exclusions and Limitations” section of this EOC for details.

<b>Benefit</b>	<b>You Pay</b>
<b>Dental Office Visit Charge</b>	\$0
<b>Benefit Maximum</b>	\$1,250
<b>Preventive and Diagnostic Services</b>	<b>You Pay</b>
Oral Exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
<b>Basic Restorative Services</b>	<b>You Pay</b>
Routine fillings	50%
Crowns (plastic/acrylic and steel)	50%
Simple extractions	50%
<b>Oral Surgery</b>	<b>You Pay</b>
Surgical tooth extractions including diagnosis and evaluation	50%
Major Oral Surgery	50%
<b>Periodontics</b>	<b>You Pay</b>
Diagnosis and evaluation	50%
Treatment of gum disease	50%
Scaling and root planing	50%
Periodontal Maintenance (Current Dental Terminology Code 4910)	No additional charge
<b>Endodontics</b>	<b>You Pay</b>
Root canal, related therapy, including diagnosis and evaluation	50%
<b>Major Restoration Services</b>	<b>You Pay</b>
Gold or porcelain crowns	50%

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Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	Not Covered
<b>Removable Prosthetic Services</b>	<b>You Pay</b>
Full and partial dentures	50%
Relines	50%
Rebases	50%
<b>Emergency Care</b>	<b>You Pay</b>
From Dental Group Providers	\$25 for Emergency and Urgent Care visits on the same or next business day plus any other Charges that normally apply.
From non-Dental Group providers	All Charges over \$100
<b>Other Benefits</b>	<b>You Pay</b>
Nightguards	10%
<b>Nitrous oxide</b>	
Adults and children age 13 years and older	\$15.00
Children age 12 years and younger	No Charge
<b>Questions? Call Membership Services (M-F, 8am – 6pm)</b> Portland: 503-813-2000, outside Portland: 1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010	
This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.	

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**ODS Preferred Plan.** In this plan, you pay less if you see dentists in the plan's preferred network, which includes more than 600 dentists throughout the state. If you continue to see the same dentist every year, your payment level for basic care drops by 10 percent per year. Some waiting periods apply; see the plan's member handbook.

Following is the Benefit Summary for the ODS Preferred plan.

**ODS Preferred**  
Benefit Summary – Preferred Option Plan

Calendar year maximum.....	\$1,750.00
Calendar year deductible per individual.....	\$ 50.00
Calendar year deductible entire family .....	\$ 150.00

Service	In Network Benefits	Out-of-Network Benefits
<b>Preventive - Deductible Waived</b> Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	<b>100%</b>	<b>90%</b>
<b>Basic - Deductible Applies</b> Restorative Dentistry Oral Surgery Endodontics Periodontics	<b>1st year-80%</b> <b>2nd year-90%</b> <b>3rd year-100%</b>	<b>70%</b>
<b>Major - Deductible Applies</b> Crowns	<b>75%</b>	<b>75%</b>
<b>Major - Deductible Applies</b> Bridges Dentures Cast Restoration Implants	<b>50%</b>	<b>50%</b>
<b>Orthodontic Benefit</b> <b>\$1,500 Lifetime Maximum</b>	<b>50%</b>	<b>50%</b>

**Note: Late enrollees have a 12 month waiting period for Basic and Major services and a 24 month waiting period for Orthodontic services.**

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**ODS Traditional Plan.** In this plan, you may use any licensed dentist. Some waiting periods apply; see the plan's member handbook. Only part-time employees and retirees may enroll in the ODS Traditional Part-time and Retiree plan.

Following are the Benefit Summaries for the ODS Traditional plans.

**ODS Traditional Full-time  
Benefit Summary – Traditional Plan**

Calendar year maximum.....	\$1,750.00
Calendar year deductible per individual.....	\$ 50.00
Calendar year deductible entire family .....	\$ 150.00

Service	Benefit Amount
<b>Diagnostic &amp; Preventive - Deductible waived</b> Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	<b>100%</b>
<b>Basic - Deductible applies</b> Restorative Dentistry Oral Surgery Endodontics Periodontics	<b>80%</b>
<b>Major – Deductible applies</b> Crowns	<b>75%</b>
<b>Major - Deductible applies</b> Bridges Dentures Cast Restoration Implants	<b>50%</b>
<b>Orthodontic Benefit - \$1,500 Lifetime Maximum</b>	<b>50%</b>

<b>Note: Late enrollees have a 12 month waiting period for Basic and Major services and a 24 month waiting period for Orthodontic services.</b>
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## ODS Traditional Part-time and Retiree Benefit Summary – Traditional Plan

Calendar year maximum.....	\$1,250.00
Calendar year deductible per individual.....	\$ 50.00

Service	Benefit Amount
<b>Diagnostic &amp; Preventive - Deductible applies</b> Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	<b>100%</b>
<b>Basic - Deductible applies</b> Restorative Dentistry Oral Surgery Endodontics Periodontics	<b>50%</b>
<b>Major - Deductible applies</b> Bridges Dentures Crowns Cast Restoration	<b>50%</b>

**Note: Late enrollees have a 12 month waiting period for Basic and Major services.**

**Willamette Dental Plan.** Members who enroll in this plan must access services through Willamette dental facilities for the services to be covered; see the plan's member handbook for locations and how Willamette Dental schedules appointments..

Following is the Benefit Summary for the Willamette Dental plan.

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## Willamette Dental Benefit Summary

### *Schedule of Covered Services and Copayments*

ADA Code	Procedure	Co-payment	ADA Code	Procedure	Co-payment
<b>1. Office Visit Charge</b>			<b>4. Restorative Dentistry</b>		
			<b>a. Amalgam Restorations – Primary Teeth</b>		
		None	2110	Fillings – 1 surface	None
		None	2120	Fillings – 2 surfaces	None
		None	2130	Fillings – 3 surfaces	None
		None	2131	Fillings – 4 or more surfaces	None
<b>2. Diagnostic and Preventative Services</b>			<b>b. Amalgam Restorations – Permanent Teeth</b>		
120	Periodic oral evaluation	None	2140	Fillings – 1 surface	None
140	Limited oral evaluation-emergency	None	2150	Fillings – 2 surfaces	None
150	Comprehensive oral evaluation	None	2160	Fillings – 3 surfaces	None
210	Complete series x-rays	None	2161	Fillings – 4 or more surfaces	None
220	Periapical-first film	None	2210	Silicate – cement per restoration	None
230	Intraoral - each additional film	None	2951	Pin retention – per tooth, in addition to restoration	None
240	Intraoral - occlusal film	None	2940	Sedative filling – temporary	None
250	Extraoral - first film	None	<b>c. Resin Restorations</b>		
260	Extraoral - each additional	None	2330	Resin-1 surface (anterior only)	None
270	Bitewings - single film	None	2331	Resin-2 surfaces (anterior only)	None
		None	2332	Resin-3 surfaces (anterior only)	None
272	Bitewings – two films	None	2335	Resin-4 surfaces (anterior only)	None
274	Bitewings-four films	None	2336	Crown - resin primary anterior	None
330	Panoramic x-rays	None	2950	Core buildup, including any pins	None
1110	Teeth cleaning (prophylaxis) adult	None	2380	Resin-one surface (primary posterior only)	None
1120	Teeth cleaning (prophylaxis) child	None	2381	Resin-two surfaces (primary posterior only)	None
1203	Topical fluoride-child	None	2382	Resin-three surfaces (primary posterior only)	None
1204	Topical fluoride-adult	None	<b>d. Inlay/Onlay (cast restorations)</b>		
1310	Diet modification	None	2510	Inlay-gold 1 surface	\$190
1320	Tobacco counseling	None	2520	Inlay-gold 2 surfaces	\$190
		None	2530	Inlay-gold 3 or more surfaces	\$190
1330	Oral Hygiene Instruction	None	2543	Onlay-gold 3 surfaces	\$190
		None	2544	Onlay-gold 4 or more surfaces	\$190
1351	Sealant/tooth	None	2610	Inlay-porcelain/ceramic 1 surface	\$190
		None	2620	Inlay-porcelain/ceramic 2 surfaces	\$190
415	Microscopic evaluation	None	2630	Inlay-porcelain/ceramic 3 surfaces	\$190
460	Pulp vitality test	None	2644	Onlay-porcelain 4 or more surfaces	\$190
510	Histopathologic examination	None	2910	Recement inlay	None
<b>3. Space Maintainers</b>					
1510	Space Maintainer – unilateral-fixed	None			
1515	Space Maintainer – bilateral-fixed	None			
1520	Space Maintainer – unilateral-removable	None			
1525	Space Maintainer – bilateral removable	None			
1550	Space Maintainer – recement	None			

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ADA Code	Procedure	Co-payment	ADA Code	Procedure	Co-payment
<b>5. Crowns</b>			<b>6. Periodontics</b>		
2710	Crown-resin laboratory	\$190	4210	Gingivectomy or gingivoplasty – per quadrant	None
2740	Crown-porcelain/ceramic (anterior only)	\$190	4211	Gingivectomy – per tooth	None
2750	Crown-porcelain/metal	\$190	4220	Gingival curettage – per quadrant	None
2790	Full cast crown – gold	\$190	4240	Gingival flap inclusion - per quadrant	None
2810	¾ crown – gold	\$190	4249	Crown lengthening hard tissue	None
2920	Recement crown	None	4250	Mucogingival surgery – per quadrant	None
2970	Temporary crown for fractured tooth	None	4260	Osseous surgery – per quadrant	\$190
2930	Stainless Steel crown-primary	None	4263	Bone replacement graft – 1 <sup>st</sup> site	None
2931	Stainless Steel crown-permanent	None	4264	Bone graft – each additional site	None
2932	Crown-prefabricated resin	None	4270	Pedicle soft tissue graft procedure	None
2933	Crown-prefabricated stainless steel w/resin window	None	4271	Free soft tissue graft procedure	None
2954	Prefabricated dowel post & core	None	4273	Subepithelial connective graft	None
2955	Post removal (no endo therapy)	None	4274	Distal wedge procedure	None
2970	Temporary crown (fractured tooth)	None	4341	Periodontic scale & root plane – per quadrant	None
2980	Repair crown	None	4355	Preliminary full-mouth debridement	None
<b>6. Endodontics</b>			4381	Antimicrobial irrigation	None
3110	Pulp cap-direct except final restoration	None	4910	Periodontic maintenance following therapy	None
3120	Pulp cap-indirect	None	<b>8. Prosthetics</b>		
3220	Pulpotomy	None	5110	Complete (upper denture)	\$190
3230	Pulpal therapy – primary anterior	None	5120	Complete (lower denture)	\$190
3240	Pulpal therapy – primary posterior	None	5130	Immediate (upper denture)	\$190
3310	Root canal therapy – anterior	None	5140	Immediate (lower denture)	\$190
3320	Root canal therapy – bicuspid	None	5213	Partial (upper denture)	\$190
3330	Root canal therapy – molar	None	5281	Partial-removable unilateral	\$190
3346	Retreatment – anterior	None	5410	Adjustment – complete denture, upper	None
3347	Retreatment – bicuspid	None	5411	Adjustment – complete denture, lower	None
3348	Retreatment – molar	None	5421	Adjustment – partial denture, upper	None
3351	Apexification – initial visit	None	5422	Adjustment – partial denture, lower	None
3352	Apexification – interim visit	None	5510	Repair broken denture no teeth damaged	None
3353	Apexification – final visit	None	5520	Repair denture replace missing or broken teeth (each tooth)	None
3410	Apicoectomy – anterior	None	5620	Repair partial cast framework	None
3421	Apicoectomy – bicuspid 1 <sup>st</sup> root	None	5630	Repair or replace partial clasp	None
3425	Apicoectomy – molar 1 <sup>st</sup> root	None	5640	Replace teeth – partial per tooth	None
3426	Apicoectomy – each additional root	None	5650	Add tooth to existing partial	None
3430	Retrograde filling – per root	None	5660	Add clasp to existing partial	None
3450	Root amputation per tooth	None	5710	Rebase complete upper denture	None
3920	Hemisection	None	5711	Rebase complete lower denture	None
3950	Canal prep-preform dowel/post	None	5720	Rebase upper partial	None

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ADA Code	Procedure	Co-payment	ADA Code	Procedure	Co-payment
5721	Rebase lower partial	None	7240	Removal of impacted tooth – complete bony	None
5730	Reline complete upper denture (chairside)	None	7241	Removal of impacted tooth – complete bony with complications	None
5731	Reline complete lower denture (chairside)	None	7250	Surgical removal residual root	None
5740	Reline upper partial (chairside)	None	7260	Oroantral fistula closure	None
5741	Reline lower partial (chairside)	None	7270	Tooth re-implantation	None
5750	Reline upper denture - lab	None	7291	Transseptal fiberotomy	None
5751	Reline lower denture – lab	None	7310	Alveoloplasty w/exposure-per quadrant	None
5760	Reline upper partial – lab	None	7320	Alveoloplasty w/o exposure-per quadrant	None
5761	Reline lower partial – lab	None	7340	Vestibuloplasty	None
5810	Interim denture – upper	\$95	7350	Vestibuloplasty – more complex	None
5811	Interim denture – lower	\$95	7470	Removal of exostosis	None
5820	Interim partial – upper	\$95	7960	Frenectomy	None
5821	Interim partial – lower	\$95	7281	Surgical exposure to aid eruption	None
5850	Tissue conditioning – upper	None	7510	I & D intraoral soft tissue	None
5851	Tissue conditioning – lower	None	7520	I & D extraoral soft tissue	None
5860	Overdenture – complete	\$190	7530	Remove foreign body – soft tissue	None
5861	Overdenture – partial	\$190	7540	Remove foreign body – hard tissue	None
5986	Fluoride gel custom trays	None	7670	Stabilization splint-alveolus	None
<b>9. Pontics (Bridge)</b>			7910	Suture small wound up to 5 cm	None
6210	Pontic, cast (per tooth)	\$190	7911	Complicated suture up to 5 cm	None
6240	Pontic (per tooth); porcelain/metal	\$190	7940	Osteoplasty	None
6241	Pontic (per tooth) maryland bridge	\$190	7970	Excision hyperplastic tissue	None
6545	Maryland bridge abutment	\$190	7971	Excision of pericoronal flap	None
6720	Crown-resin/metal abutment	\$190	<b>11. Anesthesia</b>		
6750	Crown-porcelain metal abutment	\$190	9110	Palliative (emergency) minor	None
6780	Crown ¾ cast metal abutment	\$190	9230	Nitrous Oxide (per visit)	None
6790	Crown – full gold abutment	\$190	9220	General Anesthesia – 1 <sup>st</sup> 30 minutes	Not covered
6930	Recement bridge	None	9221	General Anesthesia – Each Additional 15 minutes	Not covered
6972	Prefabricated post/core in addition to bridge	None	<b>12. Miscellaneous</b>		
6973	Core build-up w/wo pins	None	9310	Consultation – per session	None
6975	Coping – metal	None	9910	Desensitizing medicaments	None
6980	Bridge repair	None	9430	Observation visit	None
<b>10. Oral Surgery</b>			9440	Emergency treatment – after office hours	None
7110	Routine extraction – single tooth	None	9951	Occlusal adjustment - simple	None
7120	Each additional tooth – routine extraction	None	9952	Occlusal adjustment - complete	None
7130	Root removal	None	9970	Enamel microabrasion	None
7210	Surgical extraction – erupted	None	9420	Hospital Visit – exam (service co-pays still apply)	\$125
7220	Removal of impacted tooth – soft tissue	None		Cancellation of appointment without 24 hours notice	\$20
7230	Removal of impacted tooth – partial bony	None		Out of area emergency reimbursement	\$150

**13. Exclusions See Exclusions section of your Certificate.**

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**Premium Rates [Effective Jan. 1, 2010]**

The state, as the employer, provides a monthly benefit amount for employees. The employer's payroll administration applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the benefit amount. The amount is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

<b>2010 Employee Dental Plan Monthly Premium Rates</b>				
	<b>Employees</b>	<b>Employee &amp; Spouse/Partner</b>	<b>Employee &amp; Children</b>	<b>Employee &amp; Family</b>
<b>Kaiser Permanente</b>	\$72.35	\$96.95	\$83.21	\$99.12
<b>ODS Preferred</b>	71.33	95.58	82.02	97.72
<b>ODS Traditional</b>	77.21	103.48	88.80	105.79
<b>Willamette Dental Group</b>	75.23	100.81	86.52	103.06
<b>Kaiser Permanente Part-time</b>	53.93	72.26	62.02	73.89
<b>ODS Part-time</b>	55.56	74.45	63.90	76.12

<b>2010 COBRA Dental Plan Monthly Premium Rates</b>					
	<b>Self</b>	<b>Self &amp; Spouse/ Partner</b>	<b>Self &amp; Children</b>	<b>Self &amp; Family</b>	<b>Child(ren) Only<sup>1</sup></b>
<b>Kaiser Permanente</b>	\$73.79	\$98.88	\$84.86	\$101.09	\$38.37
<b>ODS Preferred</b>	72.74	97.48	83.65	99.67	37.83
<b>ODS Traditional</b>	78.75	105.53	90.56	107.89	40.95
<b>Willamette Dental Group</b>	76.72	102.82	88.24	105.11	39.90
<b>Kaiser Permanente Part-time</b>	55.00	73.70	63.25	75.36	28.60
<b>ODS Part-time &amp; Retiree</b>	56.67	75.93	65.17	77.64	29.47

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<b>2010 Retiree Dental Plan Monthly Premium Rates</b>					
	<b>Retiree</b>	<b>Retiree &amp; Spouse/ Partner</b>	<b>Retiree &amp; Children</b>	<b>Retiree &amp; Family</b>	<b>Child(ren) Only<sup>1</sup></b>
<b>Kaiser Permanente</b>	\$72.64	\$97.33	\$83.54	\$99.52	\$37.77
<b>ODS Preferred</b>	71.61	95.96	82.35	98.11	37.24
<b>ODS Traditional</b>	77.52	103.89	89.15	106.21	40.31
<b>Willamette Dental Group</b>	75.53	101.21	86.86	103.47	39.28
<b>Kaiser Permanente Retiree</b>	54.15	72.55	62.27	74.18	28.16
<b>ODS Retiree</b>	55.78	74.75	64.16	76.43	29.01

<sup>1</sup> Child(ren) Only coverage is available only to COBRA & Retiree participants.

<b>2010 Self-pay Dental Plan Monthly Premium Rates</b>				
	<b>Self</b>	<b>Self &amp; Spouse/ Partner</b>	<b>Self &amp; Children</b>	<b>Self &amp; Family</b>
<b>Kaiser Permanente</b>	\$72.35	\$96.95	\$83.21	\$99.12
<b>ODS Preferred</b>	71.33	95.58	82.02	97.72
<b>ODS Traditional</b>	77.21	103.48	88.80	105.79
<b>Willamette Dental Group</b>	75.23	100.81	86.52	103.06

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***Premium Rates [Discontinues Jan. 1, 2010]***

The state, as the employer, provides a monthly benefit amount for employees. The employer's payroll administration applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the benefit amount. The amount is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

<b>2009 Employee Dental Plan Monthly Premium Rates</b>				
	<b>Employees</b>	<b>Employee &amp; Spouse/Partner</b>	<b>Employee &amp; Children</b>	<b>Employee &amp; Family</b>
<b>Kaiser Permanente</b>	\$69.88	\$93.64	\$80.36	\$95.73
<b>ODS Preferred</b>	68.45	91.73	78.71	93.78
<b>ODS Traditional</b>	74.10	99.30	85.22	101.53
<b>Willamette Dental Group</b>	74.83	100.27	86.05	102.51
<b>Kaiser Permanente Part-time &amp; Retiree</b>	52.09	69.80	59.90	71.37
<b>ODS Part-time &amp; Retiree</b>	53.32	71.46	61.33	73.06

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***Dental Plan Comparison [Effective Jan. 1, 2010]***

The following table allows you to compare PEBB's dental plan options on a side-by-side basis.

<b>2010 PEBB Full-time &amp; Part-time Dental Plans Comparison</b>							
Plan Type	Kaiser Traditional		Willamette	ODS			
	FT	PT		Traditional	PT	Preferred	
Type of Provider	Kaiser	Kaiser	Willamette	Any	Any	Preferred	Non-preferred
Annual/person max	\$1,750	\$1,250	None	\$1,750	\$1,250	\$1,750	\$1,750
Type of Service – You Pay							
Annual deductible (individual; family)	None	None	None	\$50; \$150	\$50/ind.	\$50; \$150	\$50; \$150
Diagnostic & preventive (cleaning, X-ray) <sup>1</sup>	0%	\$0	\$0	0%	\$0	0%	10%
Basic & maintenance (filling, root canal, oral surgery)	20%	50%	\$0	20%	50%	20% <sup>2</sup>	30%
Crowns	25%	50%	\$190 <sup>3</sup>	25%	50%	25%	25%
Implants	50%	Not - covered	Varies <sup>4</sup>	50%	Not - covered	50%	50%
Dentures	50%	50%	\$190	50%	50%	50%	50%
Orthodontia	50% <sup>5</sup>	Not - covered	\$1,200 <sup>6</sup>	50% <sup>5</sup>	Not - covered	50% <sup>5</sup>	50% <sup>5</sup>

<sup>1</sup> Routine cleaning covered once per year for patients with no risks; up two four cleanings per year covered based on dentist's assessment of patient's risks and health indicators. X-rays covered on age-based schedule.

<sup>2</sup> Decreases by 10% per calendar year if you visit preferred dentist at least once per year.

<sup>3</sup> Co-payment per tooth for crowns and bridges, per upper or lower for dentures.

<sup>4</sup> See Willamette Web site for details.

<sup>5</sup> Limited to lifetime maximum of \$1,500/person.

<sup>6</sup> Requires \$150 co-payment prior to start of treatment; applies to \$1,200 total co-pay.

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**2009 Dental Plans Coverage Comparison [Discontinues Jan. 1, 2010]**

*This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.*

Plan Type	Kaiser Traditional		Willamette	ODS			
	FT	PT&R		Traditional	PT&R	Preferred	
Type of Providers	Kaiser	Kaiser	Willamette	Any	Any	Preferred	Nonpreferred
Annual/person max	\$1,750	\$1,250	None	\$1,750	\$1,250	\$1,750	\$1,750
<b>Type of Service and Amount You Pay</b>							
Annual deductible (individual; family)	None	None	None	\$50; \$150	\$50/ind.	\$50; \$150	\$50; \$150
Diagnostic & preventive (cleaning, X-ray) <sup>1</sup>	\$0	\$0	\$0	0%	\$0	0%	10%
Basic & maintenance (filling, root canal, oral surgery)	20%	50%	\$0	20%	50%	20% <sup>2</sup>	30%
Crowns	25%	50%	\$190 <sup>3</sup>	25%	50%	25%	25%
Implants	50%	Not covered	75%	50%	Not covered	50%	50%
Dentures	50%	50%	\$190 <sup>3</sup>	50%	50%	50%	50%
Orthodontia	50% <sup>4</sup>	Not covered	\$1,200 <sup>5</sup>	50% <sup>4</sup>	Not covered	50% <sup>4</sup>	50% <sup>4</sup>
<sup>1</sup> Routine cleaning covered once per year for patients with no risks; up to four cleanings per year covered based on dentist's assessment of patient's risks and health indicators. X-rays covered on age-based schedule							
<sup>2</sup> Decreases by 10% per calendar year if you visit preferred dentist at least once per year							
<sup>3</sup> Co-payment per tooth for crowns and bridges, per upper or lower for dentures							
<sup>4</sup> Limited to lifetime maximum of \$1,500 per person							
<sup>5</sup> Requires \$150 co-payment prior to the start of orthodontic treatment, which applies to \$1,200 out-of-pocket maximum for the benefit.							