

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

2010 PEBB Full-time & Part-time Dental Plans Comparison							
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) ¹	0%	\$0	\$0	0%	\$0	0%	10%
Basic & maintenance (filling, root canal, oral surgery)	20%	50%	\$0	20%	50%	20% ²	30%
Crowns	25%	50%	\$190 ³	25%	50%	25%	25%
Implants	50%	Not - covered	Varies ⁴	50%	Not - covered	50%	50%
Dentures	50%	50%	\$190	50%	50%	50%	50%
Orthodontia	50% ⁵	Not - covered	\$1,200 ⁶	50% ⁵	Not - covered	50% ⁵	50% ⁵

¹ 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.

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

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

⁴ See Willamette Web site for details.

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

⁶ 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
Type of Service and Amount You Pay							
Annual deductible (individual; family)	None	None	None	\$50; \$150	\$50/ind.	\$50; \$150	\$50; \$150
Diagnostic & preventive (cleaning, X-ray) ¹	\$0	\$0	\$0	0%	\$0	0%	10%
Basic & maintenance (filling, root canal, oral surgery)	20%	50%	\$0	20%	50%	20% ²	30%
Crowns	25%	50%	\$190 ³	25%	50%	25%	25%
Implants	50%	Not covered	75%	50%	Not covered	50%	50%
Dentures	50%	50%	\$190 ³	50%	50%	50%	50%
Orthodontia	50% ⁴	Not covered	\$1,200 ⁵	50% ⁴	Not covered	50% ⁴	50% ⁴
¹ 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							
² Decreases by 10% per calendar year if you visit preferred dentist at least once per year							
³ Co-payment per tooth for crowns and bridges, per upper or lower for dentures							
⁴ Limited to lifetime maximum of \$1,500 per person							
⁵ Requires \$150 co-payment prior to the start of orthodontic treatment, which applies to \$1,200 out-of-pocket maximum for the benefit.							