

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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Public Employees' Benefit Board Summary Plan Description

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.

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

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Gold or porcelain crowns	25%
Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	50% up to Benefit Maximum
Removable Prosthetic Services	You Pay
Full and partial dentures	50%
Relines	50%
Rebases	50%
Emergency Care	You Pay
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
Other Benefits	You Pay
Nightguards	10%
Nitrous oxide	
Adults and children age 13 years and older	\$15.00
Children age 12 years and younger	No Charge
Questions? Call Membership Services (M-F, 8am – 6pm)	
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.

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

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Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	Not Covered
Removable Prosthetic Services	You Pay
Full and partial dentures	50%
Relines	50%
Rebases	50%
Emergency Care	You Pay
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
Other Benefits	You Pay
Nightguards	10%
Nitrous oxide	
Adults and children age 13 years and older	\$15.00
Children age 12 years and younger	No Charge
Questions? Call Membership Services (M-F, 8am – 6pm) 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
Preventive - Deductible Waived Examination/X-rays Prophylaxis (cleanings) Fissure Sealants	100%	90%
Basic - Deductible Applies Restorative Dentistry Oral Surgery Endodontics Periodontics	1st year-80% 2nd year-90% 3rd year-100%	70%
Major - Deductible Applies Crowns	75%	75%
Major - Deductible Applies Bridges Dentures Cast Restoration Implants	50%	50%
Orthodontic Benefit \$1,500 Lifetime Maximum	50%	50%

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

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 Part-time and Retiree Benefit Summary – Traditional Plan

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

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

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

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ADA Code	Procedure	Co-payment	ADA Code	Procedure	Co-payment
5. Crowns			6. Periodontics		
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 st 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
6. Endodontics			4381	Antimicrobial irrigation	None
3110	Pulp cap-direct except final restoration	None	4910	Periodontic maintenance following therapy	None
3120	Pulp cap-indirect	None	8. Prosthetics		
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 st root	None	5630	Repair or replace partial clasp	None
3425	Apicoectomy – molar 1 st 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
9. Pontics (Bridge)			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	11. Anesthesia		
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 st 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	12. Miscellaneous		
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
10. Oral Surgery			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.