PREMERA BLUE CROSS

Willamette Dental Group

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	PC: WILLAMETTE DENTAL - $25 COPAY / $30 SPECIALIST	
	WILLAMETTE DENTAL NETWORK	**OUT-OF-NETWORK**
GENERAL COST SHARES		
Deductible (Individual/Family)	$0/$0	Not Covered
Office Visit	$25 Copay, applies to General and Orthodontic Office Visit	Not Covered
Maximum Per Year	No Annual Maximum	Not Covered
DIAGNOSTIC AND PREVENTIVE SERVICES		
Routine and Emergency Exams	Covered with Office Visit Copay	Not Covered
X-Rays	Covered with Office Visit Copay	Not Covered
Teeth Cleaning	Covered with Office Visit Copay	Not Covered
Fluoride Treatment	Covered with Office Visit Copay	Not Covered
Sealants	Covered with Office Visit Copay	Not Covered
Head and Neck Cancer Screening	Covered with Office Visit Copay	Not Covered
Oral Hygiene Instruction	Covered with Office Visit Copay	Not Covered
Periodontal Charting	Covered with Office Visit Copay	Not Covered
Periodontal Evaluation	Covered with Office Visit Copay	Not Covered
RESTORATIVE DENTISTRY		
Fillings	$35 Copay	Not Covered
Porcelain-Metal Crown	$400 Copay	Not Covered
PROSTHODONTICS		
Complete Upper or Lower Denture	$500 Copay	Not Covered
Bridge (per Tooth)	$400 Copay	Not Covered
ENDODONTICS AND PERIODONTICS		
Root Canal Therapy - Anterior	$200 Copay	Not Covered
Root Canal Therapy - Bicuspid	$275 Copay	Not Covered
Root Canal Therapy - Molar	$350 Copay	Not Covered

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DENTAL PLAN	**PC: WILLAMETTE DENTAL - $25 COPAY / $30 SPECIALIST**	
	WILLAMETTE DENTAL NETWORK	**OUT-OF-NETWORK**
Osseous Surgery (per Quadrant)	$400 Copay	Not Covered
Root Planing (per Quadrant)	$125 Copay	Not Covered
ORAL SURGERY		
Routine Extraction (Single Tooth)	$25 Copay	Not Covered
Surgical Extraction	$200 - $300 Copay	Not Covered
IMPLANTS		
Implant Surgery (1 Implant PCY; $1500 Implant Annual Max)	$0 Copay	Not Covered
ORTHODONTIA TREATMENT		
Pre-Treatment	$150 Copay, applies to Comprehensive Treatment	Not Covered
Comprehensive Treatment	$2,800 Copay	Not Covered
MISCELLANEOUS		
Local Anesthesia	Covered with Office Visit Copay	Not Covered
Dental Lab Fees	Covered with Office Visit Copay	Not Covered
Nitrous Oxide	$40 Copay	Not Covered
Specialty Office Visit	$30 Copay	Not Covered
Emergency Dental Care	Member pays copays that normally apply to the services provided	If out of area, you pay charges in excess of $100 *

This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms under which the program may be continued in force. This benefit highlight is not a contract. Applicable frequency and benefit limits are prescribed by a Willamette Dental Group provider. For full coverage provisions, including a description of waiting periods, limitations and exclusions, please contact Customer Service at Willamette Dental Group.

For Willamette Dental locations near you, please see the provider finder tool at: **https://locations.willamettedental.com/**

To schedule an appointment, and to learn more about your benefits, please call: **1.855.4DENTAL (1-855-433-6825)**

**Out of area emergency benefit only applies if you are 50 miles or more from a Willamette Dental Group office.*