

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 - \$20 COPAY / \$30 SPECIALIST	
	WILLAMETTE DENTAL NETWORK	OUT-OF-NETWORK	
GENERAL COST SHARES			
Deductible (Individual/Family)	\$0/\$0	Not Covered	
Office Visit	\$20 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	\$30 Copay	Not Covered	
Porcelain-Metal Crown	\$300 Copay	Not Covered	
PROSTHODONTICS			
Complete Upper or Lower Denture	\$400 Copay	Not Covered	
Bridge (per Tooth)	\$300 Copay	Not Covered	
ENDODONTICS AND PERIODONTICS			
Root Canal Therapy - Anterior	\$150 Copay	Not Covered	
Root Canal Therapy - Bicuspid	\$225 Copay	Not Covered	
Root Canal Therapy - Molar	\$300 Copay	Not Covered	

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	WILLAMETTE DENTAL NETWORK	OUT-OF-NETWORK
Osseous Surgery (per Quadrant)	\$350 Copay	Not Covered
Root Planing (per Quadrant)	\$115 Copay	Not Covered
ORAL SURGERY		
Routine Extraction (Single Tooth)	\$20 Copay	Not Covered
Surgical Extraction	\$175 - \$275 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	\$2,500 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.