SUMMARY OF BENEFITS

Washington Small Group Plan Comparison with Rates – 2025

Willamette Dental Group

COVERED BENEFITS	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5
Annual Maximum	No Annual Maximum*				
Deductible	No Deductible				
General or Orthodontic Office Visit	$10 per Visit	$10 per Visit	$15 per Visit	$20 per Visit	$25 per Visit
DIAGNOSTIC & PREVENTIVE SERVICES					
Routine & Emergency Exams	Covered with your Office Visit Copay				
X-rays	Covered with your Office Visit Copay				
Teeth Cleaning	Covered with your Office Visit Copay				
Fluoride Treatment	Covered with your Office Visit Copay				
Sealants (per Tooth)	Covered with your Office Visit Copay				
Head and Neck Cancer Screening	Covered with your Office Visit Copay				
Oral Hygiene Instruction	Covered with your Office Visit Copay				
Periodontal Charting	Covered with your Office Visit Copay				
RESTORATIVE DENTISTRY					
Fillings	Covered with the Office Visit Copay				
Porcelain-Metal Crown	$150	$200	$250	$275	$400
PROSTHODONTICS					
Complete Upper or Lower Denture	$150	$275	$300	$275	$500
Bridge (per Tooth)	$150	$200	$250	$275	$400
ENDODONTICS & PERIODONTICS					
Root Canal Therapy - Anterior	$50	$75	$100	$125	$150
Root Canal Therapy - Bicuspid	$100	$100	$125	$200	$250
Root Canal Therapy - Molar	$150	$125	$150	$275	$350
Osseous Surgery (per Quadrant)	$150	$200	$250	$275	$400
Root Planing (per Quadrant)	$60	$50	$60	$60	$100
ORAL SURGERY					
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay				
Surgical Extraction	$115	$115	$125	$150	$190
ORTHODONTIA TREATMENT					
Pre-Orthodontia Treatment	$150**	$150**	$150**	$150**	$150**
Comprehensive Orthodontia Treatment	$2,000	$1,800	$2,500	$2,800	$2,800
MISCELLANEOUS					
Local Anesthesia	Covered with your Office Visit Copay				
Dental Lab Fees	Covered with your Office Visit Copay				
Nitrous Oxide	$40				
Specialty Office Visit	$30 per Visit				
Out of Area Emergency Care Reimbursement	Up to $100				
2025 MONTHLY PREMIUM RATES					
Employee	$74.42	$69.13	$63.23	$53.51	$47.69
Employee & Spouse	$145.19	$134.75	$123.34	$104.72	$93.01
Employee & Child(ren)	$152.65	$141.72	$129.64	$109.79	$97.69
Employee & Family	$230.58	$214.25	$196.08	$165.91	$147.81

*TMJ and orthognathic surgery have benefit maximums. **Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Washington, Inc.
Washington small groups (5-50 eligible employees) are required to have a minimum of 5 enrollees regardless of group size. Presented are most common procedures covered by the plan. The certificate of coverage will contain a complete description of covered benefits and copays.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
015S-WA(1/25)R

EXCLUSIONS AND LIMITATIONS

Willamette Dental Group

This is only a summary. The certificate of coverage contains a complete description of the limitations and exclusions.

Exclusions

- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services, initiated prior to the effective date of coverage.
- Dental implants, including attachment devices, maintenance and dental implant - related services.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service that is not llisted as covered.
- Experimental or investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- Hospitalization care outside of dental office for dental procedures, physician services, or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances. Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for the treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services that are not listed as covered in the contract.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

- If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
- Services listed in the contract, which are provided to correct congenital anomalies will be covered for dependent children if dental necessity has been established.
- The retreatment of root canal therapy performed by a Willamette Dental Group dentist will be covered as part of the initial treatment for the first 24 months. The retreatment of root canal therapy performed by a non-participating provider will be subject to the applicable copayments.
- General anesthesia is covered with the copays specified in the contract if: it is preformed in a dental office, it is provided in conjunction with a covered service, and it is dentally necessary because the enrollee is under the age of 7, developmentally disabled, or physically handicapped.
- The services provided by a dentist in a hospital or similar setting are covered if a hospital or similar setting is medically necessary; the services are authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and the application copays are paid.
- The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.