Summary of Benefits



OREGON EDUCATORS BENEFITS BOARD - OR91 - 10/1/2025

Annual maximum No annual maximum' Deductible No deductible General & ortho office visit Yau pay \$20 per visit ² DIAGNOSTIC & PREVENTIVE SERVICES Covered with the office visit copay X-rays Covered with the office visit copay Teeth cleaning Covered with the office visit copay Teeth cleaning Covered with the office visit copay Fluoride treatment Covered with the office visit copay Sealants (per tooth) Covered with the office visit copay Periadontal charting & evoluation Covered with the office visit copay Oral hygiene instruction Covered with the office visit copay Periadontal charting & evoluation Covered with the office visit copay Periadontal charting & evoluation Covered with the office visit copay Porcelain-metal crown You pay a \$250 copay ³ PROSTHODONTICS ENDODONTICS Complete upper or lower denture You pay a \$50 copay Root canal therapy - naterior You pay a \$50 copay Root canal therapy - naterior You pay a \$50 copay Root canal therapy - molar You pay a \$50 copay Orsel with the office visit copay Covered with the office visit copay Orsel waint (per quadrant) Covered with the office visit copay Root canal therapy - molar You pay a \$50	COVERED BENEFITS	COPAYS
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	Nitrous Oxide	You pay a \$15 copay
Out of area emergency care reimbursementYou pay charges in excess of \$100	Specialty office visit	
	Out of area emergency care reimbursement	You pay charges in excess of \$100

¹Benefits for implant surgery have a benefit maximum, if covered. ²An office visit copayment applies at each visit, in addition to any copayments for services. ³Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit. ⁴Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan. **Underwritten by Willamette Dental Insurance, Inc.**

Presented are just some of the most common procedures covered in your plan. The certificate of coverage contains a complete description of covered benefits and copays.

Exclusions and Limitations



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

EXCLUSIONS

- Bone grafting.
- 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.
- Cone beam CT X-rays and tomographic surveys.
- Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
- A dental implant surgically placed prior to the member's effective date of coverage that has not received final restoration or a dental implant for treatment of a primary or transitional dentition.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- Exams or consultations needed solely in connection with a service not listed 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.
- General anesthesia or moderate sedation.
- Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
- Maintenance, repair, replacement, or completion of an existing implant started or placed by a non-

participating provider without a referral from a Willamette Dental Group, P.C. provider.

- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's effective date of coverage.
- Orthognathic surgery.
- 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, P.C. 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 the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for 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 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, P.C. dentist is covered.
- Services listed in the contract, which are provided to correct congenital or developmental malformations of the teeth and supporting structure will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group, P.C. dentist.
- When the initial root canal therapy was performed by a Willamette Dental Group, P.C. dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group, P.C. dentist will be subject to the applicable copays.
- The services provided by a dentist in a hospital setting are covered if: a hospital or similar setting is medically necessary; the services are authorized in writing by a Willamette Dental Group, P.C. dentist; the services provided are the same services that would be provided in a dental office; and applicable 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.
- The replacement of a lost occlusal guard is covered only one in a 2-year period. Repair or replacement of a broken or damaged occlusal guard is covered as needed.