Summary of Benefits

Willamette Dental

Idaho Small Group Plan Comparison – 2025

COVERED BENEFITS	I58	I28	I78	I88
Annual maximum	No annual maximum			
Deductible	No deductible			
General & ortho office visit	$15 per visit	$15 per visit	$20 per visit	$20 per visit
DIAGNOSTIC & PREVENTIVE SERVICES				
Routine & emergency exams	Covered with the office visit copay			
X-rays	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			
Head and neck cancer screening	Covered with the office visit copay			
Oral hygiene instruction	Covered with the office visit copay			
Periodontal charting	Covered with the office visit copay			
Periodontal evaluation	Covered with the office visit copay			
RESTORATIVE DENTISTRY				
Fillings	Covered with the office visit copay	$15	$15	$30
Porcelain-metal crown	$150	$200	$300	$325
PROSTHODONTICS				
Complete upper or lower denture	$200	$200	$400	$450
Bridge (per tooth)	$150	$200	$300	$325
ENDODONTICS & PERIODONTICS				
Root canal therapy – anterior	$75	$75	$75	$150
Root canal therapy – bicuspid	$100	$100	$100	$200
Root canal therapy – molar	$120	$125	$125	$250
Osseous surgery (per quadrant)	$150	$200	$250	$250
Root planing (per quadrant)	$50	$75	$85	$100
ORAL SURGERY				
Routine extraction (single tooth)	Covered with the office visit copay	$15	$15	$30
Surgical extraction	$80	$100	$125	$175
ORTHODONTIA TREATMENT				
Pre-orthodontia treatment	$150*	$150*	$150*	$150*
Comprehensive orthodontia treatment	$1,800	$2,200	$2,400	$2,500
MISCELLANEOUS				
Local anesthesia	Covered with the office visit copay			
Dental lab fees	Covered with the office visit copay			
Nitrous Oxide	$40			
Specialty office visit	$30 per visit			
Out of area emergency care reimbursement	Up to $100			

*Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Idaho, 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.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
015S-ID(3/25)

Exclusions and Limitations

Willamette Dental

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 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.
- 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, moderate sedation and deep sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- 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 occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
- 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 are covered for dependent children if dental necessity has been established.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group, P.C. dentist.
- The retreatment of root canal therapy performed by a Willamette Dental Group. P.C. 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 copays.
- The services provided by a dentist in a hospital setting must meet the requirements in the contract to be covered.
- 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.