Summary of Benefits

Willamette Dental

Association of Washington Cities - Plan 1 – SW12 – 1/1/2027

COVERED BENEFITS	COPAYS
Annual maximum	No annual maximum*
Deductible	No deductible
General & ortho office visit	You pay $10 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
Porcelain-metal crown	Covered with the office visit copay **
PROSTHODONTICS	
Complete upper or lower denture	Covered with the office visit copay **
Bridge (per tooth)	Covered with the office visit copay **
ENDODONTICS & PERIODONTICS	
Root canal therapy - anterior	Covered with the office visit copay
Root canal therapy - bicuspid	Covered with the office visit copay
Root canal therapy - molar	Covered with the office visit copay
Osseous surgery (per quadrant)	Covered with the office visit copay
Root planing (per quadrant)	Covered with the office visit copay
ORAL SURGERY	
Routine extraction (single tooth)	Covered with the office visit copay
Surgical extraction (single tooth)	Covered with the office visit copay
ORTHODONTIA TREATMENT	
Pre-orthodontia treatment	You pay a $150 copay***
Comprehensive orthodontia treatment	You pay a $1,000 copay
DENTAL IMPLANTS	
Dental implant surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local anesthesia	Covered with the office visit copay
Dental lab fees	Covered with the office visit copay
Nitrous Oxide	You pay a $10 copay
Specialty office visit	You pay $30 per visit
Out of area emergency care reimbursement	You pay charges in excess of $100

*Benefits for TMJ, implant surgery, and orthognathic surgery have a benefit maximum, if covered. **Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit. ***Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Washington, 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
028-WA(3/25)a

Exclusions and Limitations

Willamette Dental

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 performed or 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 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.
- Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
- Maintenance, repair, replacement, or completion of an existing implant that was 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 that was started or placed prior to the member's effective date of coverage.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery, unless listed as covered in the contract.
- 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, unless listed as covered in the contract.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are the 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 which impair functions of the teeth and supporting structures will be covered for dependent children if dental necessity has been established.
- 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.
- General anesthesia is covered with the copays specified in the contract, if: performed in a dental office, provided in conjunction with a covered service, and 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 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.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group, P.C. dentist.

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