SUMMARY OF BENEFITS

WASHINGTON STATE HEALTH CARE AUTHORITY - PEBB - WA82 - 1/1/2024

Willamette Dental Group

COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visit	No Visit Charge
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered at 100%
X-rays	Covered at 100%
Teeth Cleaning	Covered at 100%
Fluoride Treatment	Covered at 100%
Sealants (per Tooth)	Covered at 100%
Head and Neck Cancer Screening	Covered at 100%
Oral Hygiene Instruction	Covered at 100%
Periodontal Charting	Covered at 100%
Periodontal Evaluation	Covered at 100%
RESTORATIVE DENTISTRY	
Fillings	You pay a $10 - $50 Copay
Porcelain-Metal Crown	You pay a $100 - $175 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $140 Copay
Bridge (per Tooth)	You pay a $125 - $175 Copay
ENDODONTICS & PERIODONTICS	
Root Canal Therapy - Anterior	You pay a $100 Copay
Root Canal Therapy - Bicuspid	You pay a $125 Copay
Root Canal Therapy - Molar	You pay a $150 Copay
Osseous Surgery (per Quadrant)	You pay a $75 - $100 Copay
Root Planing (per Quadrant)	You pay a $15 - $35 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	You pay a $10 Copay
Surgical Extraction	You pay a $10 - $50 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $50 Copay**
Comprehensive Orthodontia Treatment	You pay a $1,500 Copay
DENTAL IMPLANTS	
Single Tooth Implant	You pay a $2,800 copay
2 Teeth Implant	Up to $5,464
3 Teeth Implant	Up to $7,644
MISCELLANEOUS	
Local Anesthesia	Covered at 100%
Dental Lab Fees	Covered at 100%
Out of Area Emergency Care Reimbursement	You pay charges in excess of $200***

*Treatment of TMJ has a $1000 annual maximum/ $5000 lifetime maximum. **This amount is credited towards the comprehensive orthodontia service copayment if member accepts treatment plan. ***Less Copayments

Underwritten by Willamette Dental of Washington, Inc.

This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124

015-WA82(1/24)

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 any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.

• Completing insurance forms or reports, or for providing records.

• The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage under the plan.

• Dentistry for cosmetic reasons or which is primarily intended to improve, alter, or enhance appearance. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.

• Endodontic therapy completed more than 60 days after termination of coverage.

• Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.

• Habit-breaking appliances, except as specified under the orthodontia benefit.

• Hospital care or other care outside of a dental office for dental procedures, including physician services, and additional fees charged for hospital treatment.

• Maxillofacial prosthetic services.

• Prescription and over-the-counter drugs and premedications. This includes analgesics (medications to relieve pain) and pain management drugs such as pre-medication and nitrous oxide.

• Orthodontic treatment, orthognathic treatment, or treatment of TMJ disorders which are not authorized in advance.

• Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

• Restorations or appliances dentally necessary to increase or alter the vertical dimension or to restore the occlusion Excluded procedures include restorations of tooth structure lost from attrition and restorations for the misalignment of teeth.

• Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.

• Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a plan designated provider.

• Services and related exams or consultations to the extent they are not dentally necessary for the diagnosis, care, or treatment of the condition involved.

• Services by any person other than a licensed dentist, licensed denturist, hygienist, or dental assistant within the scope of his or her lawful authority.

• 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 not listed as covered in the Certificate of Coverage.

• Services that Willamette Dental determines are experimental or investigative.

• Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

• When initial root canal therapy was performed by a plan designated provider, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable copayments will apply. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a plan designated provider will be subject to the applicable copayments.

• General anesthesia is covered with the copayments specified in the Certificate of Coverage only if: it is performed in a dental office; it is provided in conjunction with a covered service; and the plan designated provider determines that it is dentally necessary because the enrollee is under age 7, developmentally disabled, or physically handicapped.

• The services provided by a dentist in a hospital setting are covered if: a hospital or similar setting is dentally necessary; the services are pre-authorized in writing by a plan designated provider; the services provided are the same services that would be provided in a dental office; and the applicable copayments are paid.

• The replacements of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restorations denture is covered if the appliance is more than 5 years old and replacement is dentally necessary due to one of the following conditions: a tooth affecting an existing denture or bridge is extracted; the existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or the existing denture was an immediate denture to replace one or more natural teeth extracted while covered under the plan, and replacement by a permanent denture is necessary.