Summary of Benefits

Direct Option 7F and 7FK

Willamette Dental Group

BENEFIT	Members Age 19 and Above	Members Age 18 and Under
Annual Maximum	No Annual Maximum	No Annual Maximum
Deductible	No Deductible	No Deductible
Annual Out of Pocket Limit	Not Applicable	$350 – 1 child $700 – 2 or more Children
General Office Visit	$30 per Visit	$20 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES		
Routine and Emergency Exams	Covered at 100%	Covered at 100%
Routine X-rays	Covered at 100%	Covered at 100%
Teeth Cleaning	Covered at 100%	Covered at 100%
Fluoride Treatment	Covered at 100%	$5
Sealants (per Tooth)	Covered at 100%	$5
Head and Neck Cancer Screening	Covered at 100%	Covered at 100%
Oral Hygiene Instruction	Covered at 100%	Covered at 100%
Periodontal Charting	Covered at 100%	Covered at 100%
Periodontal Evaluation	Covered at 100%	Covered at 100%
RESTORATIVE DENTISTRY & PROSTHODONTICS		
Fillings	Covered at 100%	$25
Porcelain-Metal Crown	$300	$150
Complete Upper or Lower Denture	$450	$150
Bridge (per Tooth)	$300	$300
ENDODONTICS AND PERIODONTICS		
Root Canal Therapy – Anterior	$125	$75
Root Canal Therapy – Bicuspid	$225	$150
Root Canal Therapy – Molar	$325	$225
Osseous Surgery (per Quadrant)	$350	$350
Root Planing (per Quadrant)	$150	$120
ORAL SURGERY		
Routine Extraction (Single Tooth)	Covered at 100%	$40
Surgical Extraction	$175	$120
ORTHODONTIA TREATMENT		
Pre-Orthodontia Services	$150*	$150*
Comprehensive Orthodontic Services	$2,800	$2,800**
MISCELLANEOUS		
Local Anesthesia	Covered at 100%	Covered at 100%
Dental Lab Fees	Covered at 100%	Covered at 100%
Nitrous Oxide	$40	$40
Specialty Office Visit	$30	$30
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100	You pay charges in excess of $100

*Copayment credited towards the Comprehensive Orthodontic Service copayment if patient accepts treatment plan.
**Copayment for Comprehensive Orthodontic Services provided for treatment of cleft palate with or without cleft lip is included in the Annual Out of Pocket Limit. Orthodontic Services for all other purposes is $2,800 and is not included in the Annual Out of Pocket Limit.

Underwritten by Delta Dental Plan of Oregon
Dental Services provided by Willamette Dental Group, P.C.
Please refer to your Member Handbook for limitations and exclusions.

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