2025 Delta Dental PPO Plan Benefit Summary

Delta Dental of Oregon & Alaska

Bend Chamber of Commerce

Delta Dental PPO Plan - Super Plan (Preventive First)

	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member (Class 2 and Class 3)	$3,000	$3,000	$3,000
Calendar year deductible, per member	$0	$50	$50
Calendar year deductible, per family	$0	$150	$150
Class 1* (Services do not apply to the calendar year max)			
Periodic examinations / x-rays	100%	100%	100%
Prophylaxis (cleanings) / periodontal maintenance	100%	100%	100%
Sealants	100%	100%	100%
Space maintainers	100%	100%	100%
Topical application of fluoride	100%	100%	100%
Class 2			
Restorative fillings	80%	80%	80%
Oral surgery (extractions & certain minor surgical procedures)	80%	80%	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%	80%	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%	80%	80%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive services for all providers.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.DeltaDentalOR.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:

Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist:

Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non-Participating Dentists:

Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period except for evidence of clinical failure.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

This is a summary of the dental plan benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control. Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Associations.

2025 Delta Dental PPO Plan Benefit Summary

Delta Dental of Oregon & Alaska

Bend Chamber of Commerce

Delta Dental PPO Plan #1 - High Plan (Preventive First)

	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member (Class 2 and Class 3)	$1,500	$1,500	$1,500
Calendar year deductible, per member	$0	$50	$50
Calendar year deductible, per family	$0	$150	$150
Class 1* (Services do not apply to the calendar year max)			
Periodic examinations / x-rays	100%	100%	100%
Prophylaxis (cleanings) / periodontal maintenance	100%	100%	100%
Sealants	100%	100%	100%
Space maintainers	100%	100%	100%
Topical application of fluoride	100%	100%	100%
Class 2			
Restorative fillings	80%	80%	80%
Oral surgery (extractions & certain minor surgical procedures)	80%	80%	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%	80%	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%	80%	80%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive services for all providers.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.DeltaDentalOR.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:

Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist:

Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non-Participating Dentists:

Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Delta Dental of Oregon & Alaska

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period except for evidence of clinical failure.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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Delta Dental of Oregon & Alaska

2025 Delta Dental PPO Plan Benefit Summary

Delta Dental of Oregon & Alaska

Bend Chamber of Commerce

Delta Dental PPO Plan #2 - Mid Plan (Preventive First)	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member (Class 2 and Class 3)	$1,000	$1,000	$1,000
Calendar year deductible, per member	$0	$50	$50
Calendar year deductible, per family	$0	$150	$150
Class 1* (Services do not apply to the calendar year max)			
Periodic examinations / x-rays	100%	100%	100%
Prophylaxis (cleanings) / periodontal maintenance	100%	100%	100%
Sealants	100%	100%	100%
Space maintainers	100%	100%	100%
Topical application of fluoride	100%	100%	100%
Class 2			
Restorative fillings	80%	80%	80%
Oral surgery (extractions & certain minor surgical procedures)	80%	80%	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%	80%	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%	80%	80%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive services for all providers.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.DeltaDentalOR.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:
Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist:
Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non-Participating Dentists:
Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Delta Dental of Oregon & Alaska

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period except for evidence of clinical failure.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

This is a summary of the dental plan benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control. Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Associations.

Delta Dental of Oregon & Alaska

2025 Delta Dental PPO Plan Benefit Summary

Delta Dental of Oregon & Alaska

Bend Chamber of Commerce

Delta Dental PPO Plan #3 - Low Plan (Preventive First)	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member (Class 2 and Class 3)	$1,000	$1,000	$1,000
Calendar year deductible, per member	$0	$50	$50
Calendar year deductible, per family	$0	$150	$150
Class 1* (Services do not apply to the calendar year max)			
Periodic examinations / x-rays	80%	80%	80%
Prophylaxis (cleanings) / periodontal maintenance	80%	80%	80%
Sealants	80%	80%	80%
Space maintainers	80%	80%	80%
Topical application of fluoride	80%	80%	80%
Class 2			
Restorative fillings	50%	50%	50%
Oral surgery (extractions & certain minor surgical procedures)	50%	50%	50%
Endodontics (treatment of teeth with diseased or damaged nerves)	50%	50%	50%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	50%	50%	50%
Class 3			
Implants	25%	25%	25%
Crowns and other cast restorations	25%	25%	25%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	25%	25%	25%

* Deductible waived for preventive services for all providers.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.DeltaDentalOR.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:
Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist:
Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non-Participating Dentists:
Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Delta Dental of Oregon & Alaska

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period except for evidence of clinical failure.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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2025 Delta Dental Plan Benefit Summary

Delta Dental of Oregon & Alaska

Delta Dental Adult & Child Ortho AC1000	
Lifetime maximum benefit	$1,000
	What members pay
Members age 19+	50%
Members under age 19	50%

Eligible Employees and their covered dependents

How to use this dental plan
When you visit your dental provider, tell them you are a Delta Dental member.

Pre-determination
Your dental office can submit a pre-treatment plan to Delta Dental of Oregon on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

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AC1000

SUMMARY OF BENEFITS

Bend Chamber of Commerce – 1/1/2025

COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visi	You Pay $20 per Visit
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered with the Office Visit Cop
X-rays	Covered with the Office Visit Cop
Teeth Cleaning	Covered with the Office Visit Cop
Fluoride Treatment	Covered with the Office Visit Cop
Sealants (per Tooth)	Covered with the Office Visit Cop
Head and Neck Cancer Screening	Covered with the Office Visit Cop
Oral Hygiene Instruction	Covered with the Office Visit Cop
Periodontal Charting	Covered with the Office Visit Cop
Periodontal Evaluation	Covered with the Office Visit Cop
RESTORATIVE DENTISTRY	
Fillings	You Pay a $35 Copay
Porcelain-Metal Crown	You Pay a $350 Copay**
PROSTHODONTICS	
Complete Upper or Lower Denture	You Pay a $450 Copay**
Bridge (per Tooth)	You Pay a $350 Copay**
ENDODONTICS & PERIODONTICS	
Root Canal Therapy - Anterior	You Pay a $200 Copay
Root Canal Therapy - Bicuspid	You Pay a $225 Copay
Root Canal Therapy - Molar	You Pay a $275 Copay
Osseous Surgery (per Quadrant)	You Pay a $250 Copay
Root Planing (per Quadrant)	You Pay a $115 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	You Pay a $35 Copay
Surgical Extraction	You Pay a $150 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You Pay a $150 Copay***
Comprehensive Orthodontia Treatment	You Pay a $2,800 Copay
DENTAL IMPLANTS	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Cop
Dental Lab Fees	Covered with the Office Visit Cop
Nitrous Oxide	You Pay a $40 Copay
Specialty Office Vis	You Pay $30 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Benefits for implant 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 Delta Dental of Oregon with dental services provided by Willamette Dental Group, P.C. 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

Willamette Dental Group

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 provider.
- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's effective date of coverage.
- 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 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 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 dentist.
- When the initial root canal therapy was performed by a Willamette Dental Group 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 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 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.

OFFICES & SPECIALTY LOCATIONS

Visit our website at willamettedental.com
for up-to-date information about our dental offices and providers, including addresses, directions, hours and patient ratings & comments.

OREGON OFFICES

Albany
2225 Pacific Blvd. SE, Suite 201
Albany, OR 97321
General Dentistry

Beaverton
4925 SW Griffith Drive
Beaverton, OR 97005
General Dentistry
Dentures
Orthodontics
Pediatric Dentistry

Bend
62968 O.B. Riley Road, Suite 12
Bend, OR 97703
General Dentistry
Orthodontics

Corvallis
2420 NW Professional Drive, Suite 150
Corvallis, OR 97330
General Dentistry
Orthodontics

Eugene
2703 Delta Oaks Drive, Suite 300
Eugene, OR 97408
General Dentistry

Grants Pass
702 SW Ramsey Ave, Suite 224
Grants Pass, OR 97527
General Dentistry

Gresham
1107 NE Burnside Road
Gresham, OR 97030
General Dentistry

Hillsboro
5935 SE Alexander Street
Hillsboro, OR 97123
General Dentistry

Lincoln City
1105 SE Jetty Avenue, Suite B
Lincoln City, OR 97367
General Dentistry

Medford
773 Golf View Drive
Medford, OR 97504
General Dentistry
Orthodontics

Milwaukie
6902 SE Lake Road, Suite 200
Milwaukie, OR 97267
General Dentistry

Portland – Jefferson
1933 SW Jefferson Street
Portland, OR 97201
General Dentistry

Portland – Lents
8931 SE Foster Rd.,
Portland, OR 97266
General Dentistry
Dentures
Endodontics
Orthodontics
Pediatric Dentistry

Portland – Stark 1
13255 SE Stark Street
Portland, OR 97233
General Dentistry
Dentures

Portland – Stark 2
405 SE 133rd Avenue
Portland, OR 97233
General Dentistry

Salem – Lancaster
3490 NE Lancaster Drive
Salem, OR 97305
General Dentistry
Dentures
Endodontics
Oral Surgery
Orthodontics

Salem – Liberty
142 Pembrook Street SE
Salem, OR 97302
General Dentistry

Springfield
2510 Game Farm Road
Springfield, OR 97477
General Dentistry

Springfield Specialty
2530 Game Farm Road
Springfield, OR 97477
Endodontics
Oral Surgery
Orthodontics

Tigard
7095 SW Gonzaga Street
Tigard, OR 97223
General Dentistry
Endodontics
Oral Surgery
Periodontics

Tualatin
17130 SW Upper Boones Ferry Road
Durham, OR 97224
General Dentistry

Plan coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental Group dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits.

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WASHINGTON OFFICES

Bellevue
626 120th Avenue NE,
Suite B210
Bellevue, WA 98005
General Dentistry
Orthodontics

Bellingham
4164 Meridian Street, Suite 300
Bellingham, WA 98226
General Dentistry
Endodontics
Orthodontics

Everett
3216 Norton Ave
Everett, WA 98201
General Dentistry
Endodontics
Orthodontics

Kent
510 Washington Ave N
Kent, WA 98032
General Dentistry
Orthodontics

Longview
1461 Broadway Street, Suite A
Longview, WA 98632
General Dentistry

Mountlake Terrace
6505 216th Street SW,
Suite 200
Mountlake Terrace, WA 98043
General Dentistry

Olympia
4550 3rd Ave SE,
Lacey, WA 98503
General Dentistry
Dentures
Endodontics
Implants
Orthodontics
Periodontics

Pullman
1646 S Grand Avenue
Pullman, WA 99163
General Dentistry
Orthodontics

Puyallup
702 South Hill Park Drive,
Suite 201
Puyallup, WA 98373
General Dentistry
Orthodontics

Richland
1426 Fowler Street
Richland, WA 99352
General Dentistry
Implants
Endodontics
Oral Surgery
Orthodontics
Periodontics

Seattle North
11011 Meridian Ave North,
Suite 104
Seattle, WA 98133
General Dentistry
Endodontics
Implants
Orthodontics
Periodontics

Silverdale
3505 NW Anderson Hill Road
Silverdale, WA 98383
General Dentistry

Spokane – Northpointe
9717 N Nevada
Spokane, WA 99218
General Dentistry

Spokane Valley
9019 E Mission Avenue
Spokane Valley, WA 99212
General Dentistry
Endodontics
Orthodontics

Tacoma
3866 S 74th Street, Suite 200
Tacoma, WA 98406
General Dentistry
Dentures
Implants
Oral Surgery
Orthodontics
Periodontics

Tumwater
6120 SE Capitol Blvd.
Tumwater, WA 98501
General Dentistry

Vancouver – Hazel Dell
910 NE 82nd Street
Vancouver, WA 98665
General Dentistry
Orthodontics

Vancouver – Mill Plain
9609 E Mill Plain Blvd.
Vancouver, WA 98664
General Dentistry

Yakima
1200 Chesterly Drive, Ste 230
Yakima, WA 98902
General Dentistry
Orthodontics

IDAHO OFFICES

Boise
607 N. Mitchell St
Boise, ID 83704
General Dentistry
Implants
Orthodontics

Coeur d'Alene
943 W Ironwood Drive,
Suite 200
Coeur d'Alene, ID 83814
General Dentistry
Orthodontics

Idaho Falls
2860 Valencia Drive
Idaho Falls, ID 83404
General Dentistry
Orthodontics

Meridian
1075 S Wells Street
Meridian, ID 83642
General Dentistry
Endodontics
Orthodontics

Nampa
16145 N High Desert St
Nampa, ID 83687
General Dentistry

Twin Falls
452 Cheney Drive West,
Suite 150
Twin Falls, ID 83301
General Dentistry
Endodontics
Orthodontics

Plan coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental Group dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits.

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