Multnomah County Dental Plans Comparison Chart

You pay copay and coinsurance as indicated after applicable deductible until max benefits.
You then pay 100% of all costs.

	Delta Dental	Kaiser Dental	Willamette Dental
Annual Deductible	$25 per Individual; $75 per Family	None	None
Annual Maximum Benefit	$1,500 per person	None	None
Network	Any dentist operating within scope of license; Delta PPO Providers = least expensive Premier Providers = higher fees than PPO Out-of-Network Providers = most expensive and subject to balance-billing	Services must be provided, prescribed, referred or authorized by Kaiser Providers	Services must be provided, prescribed, referred or authorized by Willamette Dental Group Providers
Preventive & Diagnostic Services			
Preventative Oral exam; X-rays; Teeth cleaning; Fluoride treatments; Space maintainers	No charge	$10 copay	$10 copay
Basic Restorative Services			
Routine fillings; Crowns (plastic/acrylic & steel); Simple extractions	20% after deductible	$10 copay	$10 copay
Oral Surgery			
Surgical tooth extractions including diagnosis & evaluation	20% after deductible	$10 copay	$10 copay or $30 copay for specialist
Periodontics/Endodontics			
Diagnosis & evaluation; Treatment of gum disease; Scaling & root planing; Root canal; Related therapy	20% after deductible	$10 copay	$10 copay or $30 copay for specialist
Major Restorative Services			
Gold or porcelain crowns; Inlays; Bridge abutments; Pontics	50% after deductible	$45 copay for each crown, inlay, bridge abutment or pontic	$10 copay
Removable Prosthetic Services			
Full & partial dentures	50% after deductible	$65 copay for each full denture; $95 for each partial denture	$10 copay
Relines; Rebases	50% after deductible	$25 copay for each reline or rebase	$25 copay for each reline or rebase
Emergency Services			
In-plan providers	No special benefit Varies by service	You pay $25 for same or next day emergency/urgent services plus any other charges that normally apply	You pay $20 for visits outside regular office hours
Out-of-plan providers	You pay any coinsurance that normally applies plus all of amount exceeding reasonable & customary charges for eligible claims	You pay the balance after you are reimbursed up to $100 for qualifying claims outside the service area.	You pay the balance after you are reimbursed up to $100 for qualifying claims outside the service area.
Other Benefits			
Nightguards	50% after deductible to annual maximum	10% of the full price	10% of the full price
Nitrous oxide	Not covered	Adults and children age 13 & up $25; no charge for children age 12 & younger	$40 copay
Orthodontic Care			
	Adults and Children	**Adults and Children**	**Adults and Children**
Maximum lifetime orthodontia benefit per member (separate from dental annual max)	$3,000	$3,000	N/A
Orthodontics	You pay 50% of the first $6,000 in charges; 100% of charges thereafter	You pay 50% of the first $6,000 in treatment costs and 100% of charges thereafter; Office Visit copay applies to all visits	Pre-Orthodontia Treatment: $150 copay (applies toward $1,500 treatment copay); Orthodontia Treatment: You pay $1,500, Office Visit copay applies to all visits

These comparisons are not intended to provide comprehensive plan information. All benefits and coverage are subject to plan limitations and definitions. This summary should not be considered a guarantee of coverage. Please consult the Summary Plan Description, Evidence of Coverage, or applicable health plan for specific coverage information.