

2022 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 50

Kaiser Dental 15

Willamette Dental

	Delta Dental 50	Kaiser Dental 15	Willamette Dental
Annual Deductible	\$50 per Individual; \$150 per Family	None	None
Annual Maximum Benefit	\$2,000 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	\$15 copay	\$10 copay
Basic Restorative Services			
Routine fillings; Crowns (plastic/acrylic & steel); Simple extractions	20% after deductible	\$15 copay	\$10 copay
Oral Surgery			
Surgical tooth extractions including diagnosis & evaluation	20% after deductible	\$15 copay	\$10 copay or \$30 copay for specialist
Periodontics/Endodontics			
Diagnosis & evaluation; Treatment of gum disease; Root canal; Related therapy	20% after deductible	\$15 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			
Implants	Up to the annual max of \$2,000 that applies to all dental services. Annual \$50 deductible applies.	Up to \$2,000 annually toward an implant, which can cost approximately \$5,000-\$6,000.	Up to \$1,500 annually toward implant surgery, limit one surgery per year. Total cost is approximately \$4,500.
Nightguards	50% after deductible to annual maximum	10% of the full price	Covered with office visit copay- \$10/\$30
Nitrous oxide	Not covered	Adults and children age 13 & up \$25; no charge for children age 12 & younger	\$40 copay
Orthodontic Care			
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 treatment costs; 100% of charges thereafter	You pay 50% of the first \$6,000 in treatment costs and 100% of charges thereafter; \$15 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
<p>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.</p>			