

# Summary of Benefits

Effective Date: January 1, 2018



## City of Albany

BENEFITS	COPAYS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General & Orthodontic Office Visit	You pay a \$5 Copay per Visit
<b>DIAGNOSTIC AND PREVENTIVE SERVICES</b>	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
<b>RESTORATIVE DENTISTRY</b>	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a \$100 Copay
<b>PROSTHODONTICS</b>	
Complete Upper or Lower Denture	You pay a \$200 Copay
Bridge (per Tooth)	You pay a \$100 Copay
<b>ENDODONTICS AND PERIODONTICS</b>	
Root Canal Therapy – Anterior	Covered with the Office Visit Copay
Root Canal Therapy – Bicuspid	Covered with the Office Visit Copay
Root Canal Therapy – Molar	Covered with the Office Visit Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
<b>ORAL SURGERY</b>	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	Covered with the Office Visit Copay
<b>ORTHODONTIA TREATMENT</b>	
Pre-Orthodontia Treatment	You pay a \$150 Copay*
Comprehensive Orthodontia Treatment	You pay a \$1,800 Copay
<b>MISCELLANEOUS</b>	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a \$40 Copay
Specialty Office Visit	You pay a \$30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

\*Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

**Underwritten by Delta Dental of Oregon**

Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.