Summary of Benefits

Group Number: OR77
Effective Date: April 1, 2015

Willamette Dental Group

Lewis & Clark College

	COPAYS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	You pay $10 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
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
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a $50 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $100 Copay
Bridge (per Tooth)	You pay a $50 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a $30 Copay
Root Canal Therapy – Bicuspid	You pay a $60 Copay
Root Canal Therapy – Molar	You pay a $90 Copay
Osseous Surgery (per Quadrant)	You pay a $50 Copay
Root Planing (per Quadrant)	You pay a $30 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a $50 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay*
Comprehensive Orthodontia Treatment	You pay a $1,200 Copay
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $10 Copay
Specialty Office Visit	You pay a $30 Copay per visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Copayment credited towards the Comprehensive Orthodontic Service copayment if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc.
This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

Form No. 028-OR(6/13)
Contract No. 001-OR (1/10R), 001-OR(2/14)

Exclusions and Limitations

Willamette Dental Group

Exclusions

Bridges, crowns, dentures or any 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, services, or supplies initiated prior to the effective date of coverage

Dental implants, including attachment devices and their maintenance.

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.

Exams or consultations needed solely in connection with a service or supply not listed as covered.

Experimental or investigational services or supplies 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, moderate sedation and deep sedation.

Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.

Nightguards.

Orthognathic surgery.

Personalized restorations.

Plastic, reconstructive, or cosmetic surgery and other services or supplies, 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 or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.

Services or supplies and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.

Services or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant.

Services or supplies for the diagnosis or treatment of temporomandibular joint disorders.

Services or supplies for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.

Services or supplies for treatment of injuries sustained while practicing for or competing in a professional athletic contest.

Services or supplies for treatment of intentionally self-inflicted injuries.

Services or supplies for which coverage is available under any federal, state, or other governmental program, unless required by law.

Services or supplies not listed as covered in the contract.

Services or supplies provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons.

Services or supplies 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 or supplies listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children 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 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 copayments.

The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.

The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is dentally necessary.

Form No. 028-OR(6/13)
Contract No. 001-OR (1/10R), 001-OR(2/14)