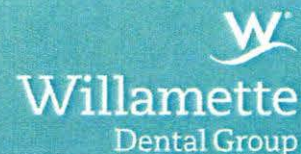


Summary of Benefits

Group Number: OR260
Effective Date: October 1st, 2017



West Linn – Wilsonville School District

| BENEFITS | COPAYS |
|--|-------------------------------------|
| Annual Maximum | No Annual Maximum |
| Deductible | No Deductible |
| General & Orthodontic Office Visit | You pay a \$10 Copay 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 | Covered with the Office Visit Copay |
| Porcelain-Metal Crown | Covered with the Office Visit Copay |
| PROSTHODONTICS | |
| Complete Upper or Lower Denture | Covered with the Office Visit Copay |
| Bridge (per Tooth) | Covered with the Office Visit Copay |
| ENDODONTICS AND PERIODONTICS | |
| 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 |
| ORAL SURGERY | |
| Routine Extraction (Single Tooth) | Covered with the Office Visit Copay |
| Surgical Extraction | Covered with the Office Visit Copay |
| ORTHODONTIA TREATMENT | |
| Pre-Orthodontia Treatment | You pay a \$150 Copay* |
| Comprehensive Orthodontia Treatment | You pay a \$1,500 Copay |
| MISCELLANEOUS | |
| 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 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.

Exclusions and Limitations

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, maintenance, and dental implant-related services.

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 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.

Hospitalization 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 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 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 which impair functions of the teeth and supporting structures 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 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 is covered if the appliance is more than 5 years old and replacement is dentally necessary.