Summary of dental benefits
Willamette University 2014-006
Oregon Dental Plan W
April 1, 2014 through March 31, 2015

<table>
<thead>
<tr>
<th>Benefit Maximum</th>
<th>$1,500 per Calendar Year</th>
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**Dental Office Visit Charge** – Applies to all visits
- **You Pay**
  - Dental Office Visit Charge: $15

**Deductible** (Per Calendar Year; applies to all services unless otherwise indicated)
- For one Member: $0
- For an entire Family: $0

**Preventive and Diagnostic Services** (oral exam, x-rays, teeth cleaning, fluoride)
- (Not subject to or counted toward the Deductible)
  - No additional charge

**Basic Restoration Services** (routine fillings, plastic and steel crowns, simple extractions)
- No additional charge

**Oral Surgery Services** (surgical tooth extractions)
- 20% Coinsurance

**Periodontics** (treatment of gum disease, scaling and root planing)
- 20% Coinsurance

**Endodontics** (root canal therapy)
- 20% Coinsurance

**Major Restoration Services** (gold or porcelain crowns, bridges)
- 20% Coinsurance

**Removable Prosthetic Services**
- Full and partial dentures: 20% Coinsurance
- Relines: 20% Coinsurance
- Rebases: 20% Coinsurance

**Emergency Dental Care**
- From Participating Providers
  - Copayments or Coinsurance that normally apply for non-emergency dental care Services.
- From Non-Participating Providers outside the Service Area
  - All Charges over $100

**Nitrous oxide** (Not subject to or counted toward the Deductible or Benefit Maximum)
- Adults and children age 13 years and older: $15
- Children age 12 years and younger: $0

**Orthodontics**
- All Members: 50% of Charges up to the $1,500 Lifetime Benefit Maximum, and 100% of Charges thereafter.

**Exclusions**
- Conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic Services.
- Dental implants unless coverage for dental implants as an additional benefit has been purchased.
- Experimental or investigational treatments.
- Fees a provider may charge for an Emergency Dental Care or Urgent Dental Care visit.
Full mouth reconstruction and occlusal rehabilitation.
Genetic testing.
Hospital call fees.
Medical or Hospital Services, unless otherwise specified in this *Summary.*
Missed appointment fees.
Orthodontic Services unless orthodontic coverage as an additional benefit has been purchased.
Drugs obtainable with or without a prescription.
Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns.
Services covered by workers’ compensation or that are the employer’s responsibility.
Services furnished by a family member.
Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Dental Care.
Speech aid prosthetic devices and follow up modifications.
Surgery to correct malocclusion or temporomandibular joint disorders.
Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

**Limitations**

- Repair or replacement due to normal wear of fixed and removable prosthetic devices that are less than five years old.
- Sedation and general anesthesia are not covered, except nitrous oxide.
- Works-in-Progress started prior to effective date of coverage.

**Questions? Call Membership Services** (M-F, 8 am-6 pm) or visit [kp.org/dental/nw](http://kp.org/dental/nw)
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..1-800-735-2900.
Language Interpretation Services, all areas..1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims review, and adjudication procedures, please see your *Evidence of Coverage (EOC)* or call Membership Services. In the case of conflict between this summary and the *EOC,* the *EOC* will prevail.