### Summary of Benefits

**Pacific University**

<table>
<thead>
<tr>
<th>COPAYS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum</td>
<td>No Annual Maximum</td>
</tr>
<tr>
<td>Deductible</td>
<td>No Deductible</td>
</tr>
<tr>
<td>General and Orthodontia Office Visit</td>
<td>You pay $10 per Visit</td>
</tr>
</tbody>
</table>

### Diagnostic and Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine and Emergency Exams</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>X-rays</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Teeth Cleaning</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Sealants (per Tooth)</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Head and Neck Cancer Screening</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Oral Hygiene Instruction</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Periodontal Charting</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Periodontal Evaluation</td>
<td>Covered with the Office Visit Copay</td>
</tr>
</tbody>
</table>

### Restorative Dentistry

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings (Amalgam)</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Porcelain-Metal Crown</td>
<td>You pay a $50 Copay</td>
</tr>
</tbody>
</table>

### Prosthodontics

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Upper or Lower Denture</td>
<td>You pay a $100 Copay</td>
</tr>
<tr>
<td>Bridge (per Tooth)</td>
<td>You pay a $50 Copay</td>
</tr>
</tbody>
</table>

### Endodontics and Periodontics

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Canal Therapy – Anterior</td>
<td>You pay a $30 Copay</td>
</tr>
<tr>
<td>Root Canal Therapy – Bicuspid</td>
<td>You pay a $60 Copay</td>
</tr>
<tr>
<td>Root Canal Therapy – Molar</td>
<td>You pay a $90 Copay</td>
</tr>
<tr>
<td>Osseous Surgery (per Quadrant)</td>
<td>You pay a $50 Copay</td>
</tr>
<tr>
<td>Root Planing (per Quadrant)</td>
<td>You pay a $30 Copay</td>
</tr>
</tbody>
</table>

### Oral Surgery

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Extraction (Single Tooth)</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Surgical Extraction</td>
<td>You pay a $50 Copay</td>
</tr>
</tbody>
</table>

### Orthodontia Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Orthodontia Treatment</td>
<td>You pay a $150 Copay*</td>
</tr>
<tr>
<td>Comprehensive Orthodontia Treatment</td>
<td>You pay a $1,200 Copay</td>
</tr>
</tbody>
</table>

### Miscellaneous

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Anesthesia</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Dental Lab Fees</td>
<td>Covered with the Office Visit Copay</td>
</tr>
<tr>
<td>Nitrous Oxide</td>
<td>You pay a $10 Copay</td>
</tr>
<tr>
<td>Specialty Office Visit</td>
<td>You pay charges in excess of $100</td>
</tr>
</tbody>
</table>

*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.
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.

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