Exclusions and Limitations

Willamette Dental

This information is made available pursuant to the requirements under RCW 48.43.016(3). Below is a general summary of the exclusions and limitations, including criteria for medical/dental necessity, for dental plans underwritten by Willamette Dental of Washington, Inc.

Please refer to the policy or Certificate of Coverage for a complete plan description, limitations, and exclusions. In the event of any conflict between this document and the policy, the benefits, terms, and conditions of the policy will govern with respect to coverage provided to enrollees.

DENTALLY NECESSARY DEFINITION

A service is "Dentally Necessary" if it is recommended by the treating Participating Provider and if all of the following conditions are met:

- The purpose of the service is to treat a diagnosed dental condition;
- It is the appropriate level of treatment considering the potential benefits and harm to the Enrollee; and
- The service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A service may be dentally necessary yet not be a covered benefit.

EXCLUSIONS

- Bridges, crowns, dentures, or 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 or services initiated prior to the effective date of coverage.
- Dental implants, including attachment devices, maintenance, and dental implant-related services, unless otherwise specified as covered in the policy.
- 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 that is not covered.
- Experimental or investigational services 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.
- Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
- Maxillofacial prosthetic services.
- Nightguards, unless otherwise specified as covered in the policy.
- Orthodontic procedures or other orthodontic treatment, unless otherwise specified as covered in the policy.

- 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 cancelled appointment 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, P.C. dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved. A service is "dentally necessary" if:
    - It is recommended by the Willamette Dental Group, P.C. dentist;
    - The purpose of the service is to treat a diagnosed dental condition;
    - It is the appropriate level of treatment considering the potential benefits and harm to the Enrollee; and
    - The service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

  A service may be dentally necessary yet not be a covered benefit.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the treatment of TMJ, unless otherwise specified as covered in the policy.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
- Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for the 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 policy.
- 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, P.C. dentist is covered.
- Services listed in the policy, 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 dental necessity has been established. If specified as covered in the policy, orthognathic surgery is covered when the Willamette Dental Group, P.C. dentist determines it is dentally necessary and authorizes the orthognathic surgery for treatment of an enrollee, under age 19, with congenital or developmental malformations. Orthognathic surgery is not covered under TrueCare Washington.

- When the initial root canal therapy was performed by a Willamette Dental Group, P.C. dentist, the retreatment of the 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, P.C. dentist will be subject to the applicable copayments.
- If specified as covered in the policy, general anesthesia is covered with the copayments specified in the policy if it is performed in a dental office; provided in conjunction with a covered service; and dentally necessary because the enrollee is under the age of 7, developmentally disabled, or physically handicapped. General anesthesia is not covered under TrueCare Washington.
- The services provided by a dentist in a hospital setting are covered if medically necessary; authorized in writing by a Willamette Dental Group, P.C. 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.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group, P.C. dentist.