Exclusions and Limitations

Willamette Dental Group

This information is made available pursuant to the requirements under RCW 41.05.074(3). Below is a general summary of the exclusions and limitations, including criteria for dental necessity, for Public Employees Benefits Board's (PEBB) group dental plan underwritten by Willamette Dental of Washington, Inc.

Please refer to the Certificate of Coverage for a complete plan description, limitations, and exclusions. In the event of any conflict between this document and the Certificate of Coverage, the Certificate of Coverage 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 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.
- Completing insurance forms or reports, or for providing records.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage.
- Dentistry for cosmetic reasons or which is primarily intended to improve, alter, or enhance appearance. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
- Endodontic therapy completed more than 60 days after termination of coverage.
- 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.
- Habit-breaking appliances, except as specified under the orthodontia benefit.
- Hospital care or other care outside of a dental office for dental procedures, including physician services, and additional fees charged for hospital treatment.
- Maxillofacial prosthetic services.
- Prescription or over-the-counter drugs and medications. This includes analgesics (medications to relieve pain) and pain management drugs such as pre-medication and nitrous oxide.
- Orthodontic treatment, orthognathic treatment, or treatment of TMJ disorders which are not prescribed by a Participating Provider.
- Replacement of lost, missing or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Restorations or appliances to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition and restorations for the malalignment of teeth.

These criteria do not imply or guarantee coverage or benefits. Please check with your plan to ensure coverage. This information is valid for the month published. This information may have changed from the prior month and is subject to change in future months.

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- Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Participating Provider.
- Services and related exams or consultations to the extent they are not Dentally Necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a dentist, denturist, hygienist, or dental assistant within the scope of his or her lawful authority.
- Services 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 not listed as covered in the Certificate of Coverage.
- Services that Willamette Dental of Washington, Inc., determines are Experimental or Investigative.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Invisalign treatment and appliances.

Limitations

- When the initial root canal therapy was performed by a Participating Provider, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After the first 24 months, the applicable Copayments will apply. When the initial root canal therapy was performed by a Non-Participating Provider, the retreatment of such root canal therapy by a Participating Provider will be subject to the applicable Copayments.
- Deep sedation/general anesthesia (D9222 & D9223) and intravenous moderate (conscious) sedation/anesthesia (D9239 & D9243) are covered with the Copayments specified in the Certificate of Coverage only if it is performed in a dental office; provided in conjunction with a covered service; and the Participating Provider determines that it is Dentally Necessary because the Enrollee is under age 7, developmentally disabled, or physically disabled.
- The services provided by a Dentist in a hospital setting are covered if a hospital or similar setting is Dentally Necessary; authorized in writing by a Participating Provider; the services provided are the same services that would be provided in a dental office; and the Hospital Call Copayment 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 due to one of the following conditions:
  - A tooth affecting an existing denture or bridge is extracted;
  - The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
  - The existing denture was an immediate denture to replace one or more natural teeth extracted while covered, and replacement by a permanent denture is necessary.

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