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 School Employees Benefits Board's (SEBB) 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 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 performed or initiated 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.
- Nitrous oxide.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance. This includes, but is not limited to laminates, veneers, or tooth bleaching.
- 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 or replacement of restorations when there no defects present in the restoration.
- Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by the Participating Provider.
- 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 dentist, denturist, hygienist, or dental assistant within the scope of his/her license.
- 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 of any kind.
- Services for the treatment of intentionally self-inflicted injuries.

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 which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services that are not listed as covered in the Certificate of Coverage.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Invisalign treatment and appliances.

Limitations

- If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. In the event the Enrollee elects a service that is more costly than the service the Participating Provider has approved, the Enrollee is responsible for the Copayment for the recommended covered service plus the cost differential between the Reasonable Cash Value of the recommended service and the Reasonable Cash Value of the more costly requested service.
- Services listed in the Certificate of Coverage 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. Dental necessity means that treatment is primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function. Orthognathic surgery is covered as specified in the Certificate of Coverage, if the Participating Provider determines orthognathic surgery is dentally necessary and authorizes the orthognathic surgery for treatment of an Enrollee who is under the age of 19 with congenital or developmental malformations.
- When the initial root canal therapy was performed by the Participating Provider, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. After 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 the 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 the following criteria are met: It is performed in a dental office; It is provided in conjunction with a Covered Service; and The Participating Provider determines that it is 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 the following criteria are met: The Participating Provider determines a hospital or similar setting is medically necessary; The services are authorized in writing by the Participating Provider; The services provided are the same services that would be provided in a dental office; and The 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 due to one of the following conditions:
  - A tooth within 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 under the plan, and replacement by a permanent denture is necessary.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Participating Provider. Crowns, casts, or other indirect fabricated restorations are dentally necessary if provided for treatment for decay, traumatic injury, or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.

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