COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic O ce Visit	You Pay $ per Visit
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered with the O ce Visit Copay
X-rays	Covered with the O ce Visit Copay
Teeth Cleaning	Covered with the O ce Visit Copay
Fluoride Treatment	Covered with the O ce Visit Copay
Sealants (per Tooth)	Covered with the O ce Visit Copay
Head and Neck Cancer Screening	Covered with the O ce Visit Copay
Oral Hygiene Instruction	Covered with the O ce Visit Copay
Periodontal Charting	Covered with the O ce Visit Copay
Periodontal Evaluation	Covered with the O ce Visit Copay
RESTORATIVE DENTISTRY	
Fillings	B l s ` o ` _ t e q d q d ` O a a e ^ ` V e p e q B l m [v
Porcelain-Metal Crown	You Pay a $ Copay**
PROSTHODONTICS	
Complete Upper or Lower Denture	You Pay a $ Copay**
Bridge (per Tooth)	You Pay a $ Copay**
ENDODONTICS & PERIODONTICS	
Root Canal Therapy - Anterior	You Pay a $ Copay
Root Canal Therapy - Bicuspid	You Pay a $ Copay
Root Canal Therapy - Molar	You Pay a $ Copay
Osseous Surgery (per Quadrant)	You Pay a $ Copay
Root Planing (per Quadrant)	You Pay a $ Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the O ce Visit Copay
Surgical Extraction	You Pay a $

Exclusions

- Bone grafting.
- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or ttings 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 e ective date of coverage.
- Cone beam CT X-rays and tomographic surveys.
- Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
- A dental implant surgically placed prior to the member's e ective date of coverage that has not received nal restoration or a dental implant for treatment of a primary or transitional dentition.
- Endodontic services, prosthetic services, and implants that were provided prior to the e ective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- Exams or consultations needed solely in connection with a service not listed as 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.
- General anesthesia or moderate sedation.
- Hospitalization care outside of a dental o ce for dental procedures, physician services, or facility fees.
- Maintenance, repair, replacement, or completion of an existing implant started or placed by a non-participating provider without a referral from a Willamette Dental Group provider.
- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's e ective date of coverage.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, 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 and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group dentist.
- 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 licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for treatment of intentionally self-in icted 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 contract.
- 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 dentist is covered.
- Services listed in the contract, which are provided to correct congenital or developmental malformations of the teeth and supporting structure will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
-