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## **INDIVIDUAL EXCLUSIVE PROVIDER ORGANIZATION DENTAL 16 INSURANCE FOR WASHINGTON INDIVIDUALS AND FAMILIES**

**This Outline of Coverage is designed to give you a  
very brief description of the important features of the policy.**

### **PLEASE READ YOUR POLICY CAREFULLY**

This outline of coverage provides a very brief description of the important features of the Policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual policy provisions are final and binding. Please refer to the Policy for a detailed description of the rights and obligations of both you and LifeMap Assurance Company.

Dental care is a vital part of maintaining and improving overall health for both children and adults. Dental disease is chronic, progressive and, at times, painful. It is also highly preventable and maintainable with routine care. Routine dental care is essential for a healthy lifestyle which is why LifeMap's Individual Exclusive Provider Organization Dental plan is available to you and your family.

### **How the Policy Works**

Under this individual dental plan, your dental care is coordinated to ensure that your expenses stay as low as possible through cost-effective dental care and an emphasis on prevention to help avoid more costly care later.

With LifeMap's Individual Exclusive Provider Organization Dental plan, you'll work with Participating Providers to maintain your oral health and enhance your overall health through routine exams and other preventive care. In order to take advantage of the benefits of this plan, you must receive your dental care from a Participating Provider.

For the purposes of this plan, Participating Providers include Willamette Dental Group, P.C. and the providers who are employed by or are under contract with Willamette Dental Group, P.C.

### **Scheduling Appointments**

Scheduling an appointment is simple. Please contact the Participating Provider's Appointment Center at 1.855.4DENTAL for information regarding the next available appointment that meets your scheduling needs.

You are free to select your Willamette Dental Group dentist and whichever location is best for you. You can find office locations and driving directions at [www.willamettedental.com](http://www.willamettedental.com). Most Participating Provider offices are open Monday through Friday and select Saturdays. The length of wait-time for an appointment may vary based on choice of provider, dental office location, appointment type and desired day or time of appointment.

If you are unable to keep an appointment, please call the Appointment Center as soon as your plans change to reschedule your dental appointment.

## OUTLINE OF COVERAGE

### Eligibility

Eligible Dependents include your Spouse and you or your Spouse's Dependent Children under age 26.

### Benefits

The Member is responsible for payment of the Visit Charge and any applicable Service Copays at the time of treatment. Please see the Schedule of Covered Services and Copays in the Policy for a complete description of the Covered Services provided by the Policy and the applicable Service Copays.

### Visit Charge

The dollar amount that is the Member's responsibility to pay for each visit to a Participating Provider. All Visit Charges are paid directly to the Participating Provider at the time of the visit. In addition to the Visit Charge, the Member may be responsible to pay a Service Copay for procedures as specified in the Schedule of Covered Services and Copays.

### Service Copay

The amount that will be the Member's responsibility to pay for each Covered Service received under the Policy as specified in the Schedule of Covered Services and Copays. All Service Copays amounts are paid directly to the Participating Provider at the time of the visit. The Service Copay is flat dollar amount in addition to the Visit Charge.

### Summary of Benefits

<b>Benefit Waiting Period</b>	No Benefit Waiting Period for Diagnostic, Preventive or most Restorative Services.  6 month Benefit Waiting Period for all Orthodontic Services, Inlay/Onlay Restorative Services and some Major Services, including Permanent Crowns and some Prosthetic Services.  See the Schedule of Covered Services and Copays in the Policy for more information.
<b>Annual Maximum</b>	No Annual Maximum
<b>Deductible</b>	No Deductible
<b>Visit Charge</b>	\$35 per visit
<b>Service Copay</b>	A summary of Covered Services and Service Copay amounts is included in this Outline of Coverage.  For a complete list of the Covered Services and the applicable Service Copay amount, please see the Schedule of Covered Services and Copays in the Policy.

## SUMMARY OF COVERED SERVICES AND COPAYS

This is a brief summary of Benefits. For full coverage provisions including a complete list of Covered Services and Exclusions, please refer to the Policy.

COPAYS	
General or Specialty Office Visit	You pay \$35 Copay per visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Periodontal Charting and Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	You pay a \$45 Copay
Porcelain-Metal Crown	You pay a \$500 Copay <sup>1</sup>
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a \$600 Copay <sup>1</sup>
Bridge (per Tooth)	You pay a \$500 Copay <sup>1</sup>
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a \$225 Copay
Root Canal Therapy – Bicuspid	You pay a \$325 Copay
Root Canal Therapy – Molar	You pay a \$425 Copay
Osseous Surgery (per Quadrant)	You pay a \$325 Copay
Root Planing (Per Quadrant)	You pay a \$100 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	You pay a \$75 Copay
Surgical Extraction	You pay a \$190 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a \$150 Copay <sup>1 2</sup>
Comprehensive Orthodontia Treatment	You pay a \$3,000 Copay <sup>1</sup>
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a \$40 Copay
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

<sup>1</sup> Benefit available after a six-month Benefit Waiting Period.

<sup>2</sup> Applies toward Comprehensive Orthodontia Copay if Member accepts treatment plan.

## EXCLUSIONS

Your Policy does not cover:

- **Aesthetic Dental Procedures** and complications arising out of such services
- **Benefits not stated**
- **Charges by any person other than a Participating Provider**, except as otherwise indicated in the Policy
- **Cosmetic/Reconstructive Services and Supplies** (certain exceptions apply)
- **Coverage available under any federal, state, or other governmental program**, except where required by law
- **Dental services which are not Necessary Dental Services**
- **Diagnostic Casts or Study Models**
- **Endodontics, bridges, crowns, and other prosthetic devices or services** if treatment was started or ordered prior to the Member's effective date or delivered more than 60 days after the Member's coverage under the Policy has terminated.
- **Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst**
- **Experimental/Investigational** treatments, procedures, services and supplies
- **Extraction of permanent teeth** for tooth guidance procedures; procedures for tooth movement
- **Full-mouth reconstruction**
- **General Anesthesia**
- **Habit-breaking or Stress-Breaking Appliances**
- **Hospitalization** for dentistry
- **Maxillofacial prosthetic services**
- **Medication and Supply Charges**
- **Military Service-Related Conditions**
- **Motor Vehicle Coverage and Other Insurance Liability**
- **Non-Direct Patient Care**
- **Occlusal Treatment** including complete occlusal adjustments and occlusal guards
- **Personalized restorations, precision attachments, and special techniques**
- **Repair or replacement of lost, stolen, or broken items**
- **Replacement of sound restorations**
- **Services and supplies for treatment of an illness or injury caused by Riot, Rebellion, War and Illegal Acts**
- **Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident**
- **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 Participating Provider
- **Services or supplies where there is no evidence of pathology, dysfunction, or disease**
- **Temporomandibular Joint (TMJ) Dysfunction Treatment**
- **Transseptal fiberotomy**
- **Treatment started prior to the Member's Effective Date under the Policy or completed after the Policy terminates**
- **Work-Related Injuries**

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## DENTAL COVERAGE OUTLINE

<b><u>Benefit Year Deductible</u></b>	<b>None</b>
<b><u>Benefit Waiting Period</u></b>	
<b>Diagnostic and Preventive Services</b>	<b>None</b>
<b>Restorative Services</b>	<b>None*</b>
*Inlay/Onlay Services only	<b>6 Months</b>
<b>Major Dental Services</b>	<b>6 Months</b>
Crowns	
Removable Prosthetic Services Including:	
Complete Dentures, Immediate Dentures,	
Partial Dentures, Overdentures	
Fixed Prosthetic Services (Bridges)	
<b>Orthodontic Services</b>	<b>6 Months</b>
<b><u>Benefit Year Maximum</u></b>	<b>None</b>
<b><u>Visit Charge</u></b>	<b>\$35</b>
<b><u>Service Copay</u></b>	<b>See the Schedule of Covered Services and Copays</b>

The Member must receive services from a Participating Provider for services to be covered under this Policy, except as otherwise specified in this Policy for emergency care and referrals. For the purposes of this Policy, Participating Providers are those providers who are employed by or are under contract with Willamette Dental Group.

The Participating Providers, who are offering the services provided in this Policy, agree that they will accept fees in the amount established by us as full payment for Covered Services except for the Visit Charge and Service Copay, which are the Member's responsibility. The Participating Providers agree that their charges to the Member for Covered Services provided will not exceed the Service Copay amounts specified in the Schedule of Covered Services and Copays of this Policy.

A list of the Willamette Dental Group offices at which the Participating Providers offer services and contact information can be found online at [www.willamettedental.com](http://www.willamettedental.com).

## **DENTAL BENEFITS**

### **Emergency Care**

The Member should first seek treatment from a Participating Provider for a Dental Emergency. If Participating Provider offices are closed, the Member may access after-hours clinical assistance by calling the Appointment Center at (855) 433-6825. When emergency services are provided after normal business hours at a Participating Provider office, the Member will be responsible for both the Visit Charge and an additional Service Copay as specified in the Schedule of Covered Services and Copays.

In the event of a Dental Emergency when the Member is more than 50 miles from a Participating Provider office:

The Member may seek treatment from any dentist for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Participating Provider office.

The Member may seek reimbursement for the cost of the Covered Services rendered up to the Out of Area Emergency Reimbursement amount, per occurrence, as specified in the Schedule of Covered Services and Copays. Based on the services received the Member will remain responsible for the Service Copay amounts as if the Member had been seen by a Participating Provider.

A written request for reimbursement must be submitted per the instructions in the Claims for Reimbursement of Emergency Treatment provision of this Policy.

### **Orthodontia Services**

The Member must be covered under this Policy for a period of 6 months to be eligible for Benefits for orthodontic treatment. Orthodontic services will be provided by a Participating Provider when a treatment plan is prepared by a Participating Provider prior to rendering orthodontic services. No Benefits will be provided for any appliances provided prior to rendering treatment.

The treatment plan is based on an examination that must take place while the Member is covered under this Policy, and the examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care. Additional services connected with orthodontic treatment will be provided subject to the Service Copay amounts found in the Schedule of Covered Services and Copays.

Once active orthodontic treatment ends, the Member must follow the post-treatment plan and keep all follow-up appointments after the Member is de-banded to avoid additional orthodontic Service Copays. Such additional orthodontic treatment would be considered to be a new case.

To receive the full Benefits of this Policy, the Member must remain covered under this Policy for the entire length of treatment. If coverage terminates prior to completion of treatment, the Service Copay will be prorated according to the extent of services received prior to termination and the charges for any remaining services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

### **Referrals**

The services of a Specialist will only be covered upon referral by a Participating Provider. The Member will be responsible for charges by the Specialist for procedures other than those specifically authorized by the Participating Provider and for any services not covered under this Policy.

### **Benefits**

Charges for Covered Services will be considered paid in full after payment of the Visit Charge and any applicable Service Copays for which the Member is responsible. The Visit Charge and Service Copay should be paid directly to the Participating Provider at the time of service. Please see the following Schedule of Covered Services and Copays for a complete description of the Benefits provided by this Policy with the applicable Service Copays listed. If alternative Covered Services can be used to treat a Member's dental condition, the Covered Service which is recommended by the treating Participating Provider will be covered.

## DEFINITIONS

Wherever used in this Policy, the following definitions will apply to the terms listed below. The masculine will include the feminine and the singular will include the plural.

"**You**" and "**your**" mean the Insured person. "**We**," "**us**" and "**our**" mean LifeMap Assurance Company.

**Benefit** means services and supplies covered under this Policy.

**Benefit Waiting Period** means the continuous length of time the Member must be covered under this Policy before becoming eligible for Benefits.

**Benefit Year** means the 12-month period beginning on your Effective Date. Your second Benefit Year begins on the anniversary of your Effective Date, and so on.

**Covered Service** means a:

1. service;
2. supply; or
3. treatment

listed in the Schedule of Covered Services and Copays of this Policy.

**Dental Emergency** means the emergent and acute onset of a symptom or symptoms that would lead a prudent person acting reasonably to believe that a condition exists that requires immediate attention, if failure to provide immediate attention would result in serious impairment to bodily functions or serious dysfunction of a bodily part, or would place the person's health in serious jeopardy. (A prudent person is someone who has an average knowledge of health and medicine.) The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or any Prosthetic Services.

**Dependent Child** means your or your Spouse's child who is under age 26 and who meets any of the following criteria:

1. your or your Spouse's natural child, stepchild, adopted child, or child legally placed with you or your Spouse for adoption;
2. a child for whom you or your Spouse have court-appointed legal guardianship;
3. a child for whom you or your Spouse are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your or your Spouse's child who is age 26 or over and chiefly dependent upon you or your Spouse for support and maintenance due to developmental disability or physical handicap that began before their 26th birthday will continue to be covered if you submit written evidence of the child's incapacity to LifeMap within 31 days of the later of the child's 26th birthday or your or your Spouse's Effective Date. After initial certification, proof of disability may be required at reasonable times as LifeMap considers necessary but not more frequently than annually after the two year period following the child's 26th birthday.

**Effective Date** means the date coverage under this Policy goes into effect. The Effective Date is shown on the Policy Schedule.



**Eligible Dependent** means the Insured's Spouse and all Dependent Children as defined above who are named on the Policy Schedule and for whom the premium has been paid.

Dependents are limited to the following:

1. your Spouse including your non-state registered domestic partner, provided that all of the following conditions are met:
  - a. you have completed, signed, and submitted an Affidavit of Non-State Registered Domestic Partnership form with regard to your domestic partner;
  - b. you and your domestic partner share a residence and the financial responsibility for the joint household and intend to continue an exclusive relationship indefinitely;
  - c. you and your domestic partner each are at least eighteen (18) years of age;
  - d. you and your domestic partner are both mentally competent to enter into a binding contract;
  - e. neither you nor your domestic partner are married to or legally separated from anyone else;
  - f. you and your domestic partner are not related to one another by blood closer than would bar marriage; and
  - g. neither you nor your domestic partner is a domestic partner of anyone else.
2. your or your Spouse's Dependent Child as defined above.

State registered Domestic Partners are included under the definition of a "Spouse".

**Experimental/Investigational** for the purposes of this Policy means a service or supply which does not meet all of the following criteria:

1. the services or supplies are in general use in the dental community in the State of Washington;
2. the services or supplies are under continued scientific testing and research;
3. the services or supplies show a demonstrable benefit for a particular illness, disease, or condition; and
4. the services or supplies are proven safe and effective.

**Insured** means the person named on the Policy Schedule. The Insured must be eligible for coverage and must pay the applicable premium in order for this Policy to take effect.

**Licensed Dentist** means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

**Licensed Denturist** means a denturist licensed in the state where treatment is rendered, who is acting within the scope of their license.

**Member** means the Insured and the Insured's Eligible Dependents, if any, who are named on the Policy Schedule.

**Necessary Dental Service** means a dental service recommended by the treating Participating Provider, who has personally evaluated the Member, and determined by the Participating Provider to be all of the following:

1. appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
2. appropriate for the diagnosed condition, disease, or injury;
3. in accordance with recognized national standards of care;
4. could not have been omitted without adversely affecting the Member's condition; and
5. not primarily for the convenience of the Member, Member's family, or provider.

A dental service may be a "Necessary Dental Service" yet not be a Covered Service under this Policy.

**Participating Provider** means Willamette Dental Group and the providers who are employed by or are under contract with Willamette Dental Group, to provide dental services to the Member.

**Participating Providers** include the following:

1. **Participating Dentist:** A Licensed Dentist who is employed by or is under contract with Willamette Dental Group as specified above.
2. **Participating Denturist:** A Licensed Denturist who is employed by or is under contract with Willamette Dental Group as specified above.

**Policy** means this document, including the application, and any riders, endorsements or amendments attached thereto.

**Reasonable Cash Value** (RCV) means the Participating Provider's usual, customary, and reasonable fee for services and supplies.

**Service Copay** means the amount that will be the Member's responsibility to pay for each Covered Service received under this Policy as specified in the Schedule of Covered Services and Copays. All Service Copay are paid directly to the Participating Provider at the time of the visit. The Service Copay is a flat dollar amount and is in addition to the Visit Charge.

**Specialist** means a Licensed Dentist who has completed additional training in one or more areas of dental treatment and who provides services to the Member upon referral by the Participating Provider.

**Spouse** means the Insured's legal wife, husband, state registered domestic partner or non-state registered domestic partner if the qualifications noted in the definition of Eligible Dependent have been met.

**Temporomandibular Joint Disorder** means a disorder that has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

**Visit Charge** means the dollar amount that will be the Member's responsibility to pay for each visit to a Participating Provider. All Visit Charges are paid directly to the Participating Provider at the time of the visit. In addition to the Visit Charge, the Member may be responsible to pay a Service Copay for procedures as specified in the Schedule of Covered Services and Copays.

**Willamette Dental Group** means Willamette Dental Group, P.C., the corporation which has signed a participating agreement with us, on behalf of itself and its affiliates, to provide dental services to the Member.

## SCHEDULE OF COVERED SERVICES AND COPAYS

**Service Copay**  
(You pay the amount noted)

### Diagnostic and Preventive Services

#### Oral Evaluations

Oral evaluation or examination ..... \$0

#### Cleanings and Fluoride Treatments

Teeth cleaning (prophylaxis) - child, through age 12..... \$0

Teeth cleaning (prophylaxis) – adult ..... \$0

Topical fluoride treatment ..... \$0

#### Radiology and Pathology

Complete series of intraoral x-rays ..... \$0

Intraoral x-rays – periapical or occlusal ..... \$0

Extraoral x-rays ..... \$0

Bitewing x-rays ..... \$0

Panoramic x-rays..... \$0

Oral / facial photographic images ..... \$0

Caries susceptibility tests ..... \$0

Pulp vitality tests..... \$0

Diagnostic casts ..... \$0

Nutritional counseling ..... \$0

Tobacco counseling..... \$0

Oral hygiene instructions ..... \$0

**Sealant (per tooth) ..... \$0**

#### Space Maintainers

Space maintainers..... \$0

Recement space maintainer ..... \$0

Removal of fixed space maintainer ..... \$0

## SCHEDULE OF COVERED SERVICES AND COPAYS

**Service Copay**  
(You pay the amount noted)

### Restorative Services

#### Fillings

##### Amalgam Restorations

Amalgam filling ..... \$45

##### Resin-Based Composite Restorations

Resin-based composite, anterior tooth..... \$70

Resin-based composite, posterior primary tooth ..... \$80

Resin-based composite - 1 surface, posterior permanent tooth ..... \$80

Resin-based composite - 2 to 4 surfaces, posterior permanent tooth..... \$132

##### Inlay/Onlay Services (cast restorations)

Inlay - metallic - 1 surface \* ..... \$325

Inlay - porcelain/ceramic - 1 surface \* ..... \$335

Inlay - metallic - 2 surfaces \* ..... \$400

Inlay - porcelain/ceramic - 2 surfaces \* ..... \$445

Onlay - metallic - 2 surfaces \* ..... \$450

Onlay - porcelain/ceramic - 2 surfaces \* ..... \$500

Inlay or Onlay - metallic or porcelain/ceramic - 3 or more surfaces \* ..... \$500

Recement inlay or onlay ..... \$0

**\*After the six month Benefit Waiting Period.**

#### Endodontic Services

Pulp cap - direct..... \$45

Pulp cap - indirect..... \$65

Pulpotomy - A pulpotomy is not the first stage of a root canal.

A pulpotomy is a separate procedure..... \$70

Pulpal debridement - primary and permanent teeth ..... \$70

Pulpal therapy ..... \$70

Endodontic therapy - anterior tooth..... \$225

Endodontic therapy - bicuspid tooth..... \$325

Endodontic therapy - molar..... \$425

Treatment of root canal obstruction - non-surgical access ..... \$0

Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth ..... \$0

Internal root repair of perforation defects ..... \$0

## SCHEDULE OF COVERED SERVICES AND COPAYS

**Service Copay**  
(You pay the amount noted)

### Endodontic Services (continued)

Retreatment - anterior tooth.....	\$225
Retreatment - bicuspid tooth.....	\$325
Retreatment - molar .....	\$425
Apexification .....	\$210
Apicoectomy - anterior.....	\$225
Apicoectomy - bicuspid.....	\$325
Apicoectomy - molar.....	\$425
Retrograde filling (per root) .....	\$0
Hemisection.....	\$425
Canal preparation and fitting of preformed dowel or post.....	\$0

### Periodontal Services

Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth, per quadrant .....	\$100
Gingivectomy or gingivoplasty - 4 or more contiguous teeth, per quadrant .....	\$325
Gingival flap, per quadrant.....	\$325
Apically positioned flap .....	\$325
Crown lengthening - hard tissue .....	\$325
Osseous surgery, per quadrant .....	\$325
Bone replacement graft .....	\$0
Surgical revision procedure, per tooth .....	\$325
Pedicle soft tissue graft procedure, per tooth.....	\$325
Subepithelial connective tissue graft, per tooth.....	\$325
Distal or proximal wedge procedure.....	\$325
Free soft tissue graft procedure, per tooth or edentulous tooth position.....	\$325
Periodontal scaling and root planing, per quadrant .....	\$100
Full-mouth debridement.....	\$0
Antimicrobial irrigation .....	\$0
Periodontal maintenance .....	\$0

## SCHEDULE OF COVERED SERVICES AND COPAYS

### Service Copay

(You pay the amount noted)

### Oral Surgery

Extraction - coronal remnants deciduous tooth .....	\$45
Extraction - erupted tooth or exposed root .....	\$75
Surgical removal - erupted tooth .....	\$155
Removal of impacted tooth-soft tissue .....	\$185
Removal of impacted tooth – partially or completely bony .....	\$190
Surgical removal of residual tooth roots .....	\$190
Coronectomy .....	\$190
Oroantral fistula closure .....	\$190
Primary closure of a sinus perforation .....	\$190
Tooth reimplantation and/or stabilization .....	\$190
Surgical access of an unerupted tooth .....	\$190
Device placement to aid eruption of impacted tooth .....	\$190
Transseptal fiberotomy/supra crestal fiberotomy .....	\$135
Alveoloplasty with or without extractions, per quadrant .....	\$0
Vestibuloplasty - ridge extension .....	\$190
Removal of lateral exostosis - maxilla or mandible .....	\$190
Removal of torus palatinus or torus mandibularis .....	\$190
Surgical reduction of osseous tuberosity .....	\$190
Incision and drainage of an abscess-intraoral or extraoral soft tissue .....	\$0
Removal of foreign body - soft or hard tissue .....	\$0
Partial ostectomy/sequestrectomy for removal of non-vital bone .....	\$0
Treatment of simple fracture – alveolus .....	\$190
Suture of a small wound or Complicated suture - up to 5 cm .....	\$0
Frenectomy .....	\$190
Excision hyperplastic tissue, per arch .....	\$190
Excision of pericoronal gingiva .....	\$190

### Anesthesia

Nitrous Oxide (per visit) .....	\$40
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## SCHEDULE OF COVERED SERVICES AND COPAYS

**Service Copay**  
(You pay the amount noted)

### Major Dental Services

#### Crowns

Crown - porcelain/ceramic substrate, porcelain fused to high noble metal, porcelain fused to noble metal, $\frac{3}{4}$ noble metal, or full cast noble metal *	\$500
Crown - resin-based composite (indirect) *	\$410
Crown - prefabricated stainless steel, prefabricated resin, or prefabricated stainless steel crown with resin window	\$90
Temporary crown for fractured tooth	\$90
Recement crown	\$0
Protective restoration	\$40
Core buildup, including any pins	\$70
Prefabricated or indirectly fabricated post & core	\$0
Post removal (no endodontic therapy)	\$0
Crown repair necessitated by restorative material failure	\$0

**\*After the six month Benefit Waiting Period.**

#### Prosthetic Services – Removable

Complete denture *	\$600
Immediate denture *	\$600
Partial denture - resin base or flexible base *	\$600
Partial denture - cast metal framework with resin base *	\$600
Removable unilateral partial denture *	\$600
Overdenture - complete or partial *	\$600
Adjust complete or partial denture	\$0
Repair broken complete denture base - no teeth damaged	\$100
Repair broken complete denture - replace missing or broken teeth (per tooth)	\$100
Repair resin denture base	\$100
Repair cast framework	\$100
Repair or replace broken clasp	\$100
Replace broken teeth (per tooth)	\$100
Add tooth or clasp to existing partial denture	\$100
Replace all teeth and acrylic on cast metal framework	\$100
Rebase complete or partial denture	\$100
Reline complete or partial denture - chairside	\$100
Reline complete or partial denture - lab	\$100
Interim complete or partial denture *	\$300
Tissue conditioning	\$0
Fluoride gel custom trays	\$0

**\*After the six month Benefit Waiting Period.**

## SCHEDULE OF COVERED SERVICES AND COPAYS

**Service Copay**  
(You pay the amount noted)

### Prosthetic Services – Fixed

Pontic - cast high noble metal, porcelain fused to high noble metal, or porcelain fused to predominately base metal *	\$500
Cast metal retainer for resin bonded fixed prosthesis *	\$500
Crown - resin with high noble metal or porcelain fused to high noble metal abutment *	\$500
Crown - ¾ cast high noble metal abutment *	\$500
Crown - full cast high noble metal abutment *	\$500
Recement bridge	\$0
Bridge repair necessitated by restorative material failure	\$0

**\*After the six month Benefit Waiting Period.**

### Orthodontic Services

#### Pre-orthodontic Service Copays

Initial orthodontic exam *	\$25 per case†
Study models and x-rays *	\$125 per case†

†These Pre-orthodontic Service Copays will be deducted from the Comprehensive Orthodontic Service Copay specified below if the Member elects to receive orthodontic treatment.

**Comprehensive Orthodontic Service Copay \*** .....\$3,000 per case

Includes the following treatments:

Limited and comprehensive orthodontic treatment of the transitional, adolescent, and adult dentition.

Interceptive orthodontic treatment of the transitional dentition.

**\*After the six month Benefit Waiting Period.**

### Miscellaneous Services

Palliative (emergency) treatment of dental pain - minor procedure	\$0
Fixed partial denture sectioning	\$0
Consultation - per session	\$0
Observation office visit	\$0
Office visit after regular office hours	\$20
Hospital or ambulatory surgical center call	\$125
Occlusal adjustment – simple	\$0
Out of Area Emergency Treatment by a Non-Participating Provider	Charges in excess of \$100
(We will reimburse up to \$100 of Covered Services)	Service Copays will still apply



## BENEFIT ILLUSTRATION

The following examples illustrate how out of pocket expenses may be calculated for different treatment scenarios. The Visit Charge and Service Copay amounts are paid directly to the Participating Provider at the time of the visit.

**If you see a Participating Provider for an oral evaluation, cleaning and bitewing x-rays the calculation of your out of pocket expenses would be as follows:**

Visit Charge	\$ 35.00
Service Copay amount(s)	
Oral evaluation or examination	+ \$ 0.00
Teeth cleaning (prophylaxis) - adult	+ \$ 0.00
<u>Bitewing x-rays</u>	+ \$ 0.00
<b>Total</b>	<b>\$ 35.00</b>

**If you see a Participating Provider for an extraction of an erupted tooth and require nitrous oxide the calculation of your out of pocket expenses would be as follows:**

Visit Charge	\$ 35.00
Service Copay amount(s)	
Extraction - erupted tooth or exposed root	+ \$ 75.00
<u>Nitrous Oxide</u>	+ \$ 40.00
<b>Total</b>	<b>\$ 150.00</b>

## EXCLUSIONS

The following are the general exclusions from coverage under this Policy. Other exclusions may apply and, if so, will be described elsewhere in this Policy. No Benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, **including any direct complications or consequences that arise from them**, unless otherwise specified.

**Aesthetic Dental Procedures** and complications arising out of such services. Including services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

**Benefits not stated** meaning services and supplies that are not identified as Benefits under this Policy.

**Charges by any person other than a Participating Provider** except for those instances indicated in the Benefits section of this Policy.

**Cosmetic/Reconstructive Services and Supplies, except in the treatment of the following:**

1. to treat a congenital anomaly for Members up to age 18; or
2. to restore a physical bodily function lost as result of injury or illness.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance and that do not primarily restore an impaired function of the body.

Reconstructive means:

1. services, procedures, and surgery performed on abnormal structures of the body that were caused by congenital defects; or
2. developmental abnormalities, trauma, infection, tumors, or disease.

Reconstructive services are generally performed to restore function, but also may be done to approximate a normal appearance.

For the purposes of this exclusion, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

**Coverage that is available under any federal, state, or other governmental program** if application is duly made therefore, except where required by law, such as for cases of emergency or for coverage provided by Medicaid.

**Dental implants**, including attachment devices and their maintenance; crowns over implants.

**Dental services which are not Necessary Dental Services** as defined by this Policy.

**Diagnostic Casts or Study Models.**

**Endodontics, bridges, crowns, or other services or prosthetic devices** requiring multiple treatment dates or fittings if treatment was started or ordered prior to the Member's Effective Date under this Policy or if the item was installed or delivered more than 60 days after the Member's coverage under this Policy has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within 60 days after termination.

**Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst**, nonodontogenic or exostosis.

**Experimental/Investigational treatments**, procedures and services, supplies, and accommodations provided in connection with Experimental/Investigational treatments or procedures.

**Extraction of permanent teeth** for tooth guidance procedures; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; craniomandibular orthopedic treatment; and other orthodontic treatment, unless specified in the Schedule of Covered Services and Copays.

**Full-mouth reconstruction.**

**General Anesthesia**, including conscious sedation and intravenous sedation, except as specified in the Schedule of Covered Services and Copays.

**Habit-breaking or stress-breaking appliances**

**Hospitalization** for dentistry.

**Maxillofacial prosthetic services.**

**Medication and Supply Charges** including take home drugs, pre-medications, therapeutic drug injections, and supplies.

**Military Service-Related Conditions** which includes services and supplies for treatment of an illness or injury caused by or incurred during service in the armed forces of any state or country.

**Motor Vehicle Coverage and Other Insurance Liability** means any expenses for services and supplies that are payable under any:

1. automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage;
2. homeowner's coverage;
3. commercial premises coverage; or
4. similar policy or insurance.

This applies when the policy or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such policy or insurance are exhausted or deemed to no longer be injury-related under the no-fault provisions of the Policy, we will provide Benefits according to this Policy.

**Non-Direct Patient Care** and services that are not direct patient care, including:

1. charges for appointments scheduled and not kept ("missed appointments");
2. charges for preparing medical reports, itemized bills or claim forms (even at our request); or
3. visits or consultations that are not in person (including telephone consultations and e-mail exchanges)

whether initiated by the Member or the Member's provider.

**Occlusal Treatment** and supplies provided in connection with dental occlusion, including the following:

1. complete occlusal adjustments; and
2. occlusal guards.

**Personalized restorations, precision attachments, and special techniques.**

**Repair or Replacement Services** and supplies provided in connection with the repair or replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen, or broken.

**Replacement of sound restorations.**

**Riot, Rebellion, War and Illegal Acts**, including services and supplies for treatment of:

1. an illness or injury caused by a Member's unlawful instigation and/or active participation in a riot or war, whether declared or undeclared; armed invasion or aggression, insurrection, or rebellion; or
2. services and supplies for treatment of an illness or injury sustained by a Member while in the act of committing an illegal act.

**Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.**

**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 Participating Provider.

**Services or supplies where there is no evidence of pathology, dysfunction, or disease** other than covered preventive services.

**Temporomandibular Joint (TMJ) Dysfunction Treatment.** Services and supplies provided in connection with Temporomandibular Joint (TMJ) dysfunction.

**Transseptal fiberotomy.**

**Treatment started prior to the Member's Effective Date under this Policy or completed after this Policy terminates, unless otherwise stated.**

**Work-Related Injuries** and expenses for services and supplies incurred as a result of any work-related injury, including any claims that are resolved pursuant to a disputed claim settlement for which a Member has or had a right to compensation.

We may require the Member to file a claim for workers' compensation benefits prior to providing any Benefits under this Policy. The only exception is if a Member is exempt from state or federal workers' compensation law.

## **THIRD PARTY LIABILITY**

This provision will apply in the event any person covered by this Policy receives treatment in connection with an illness or injury for which one or more third parties may be responsible. In that situation, Benefits are excluded under this Policy to the extent you or your Eligible Dependent receive a recovery from or on behalf of the responsible third party.

The following rules will apply to third party liability situations:

1. If a Participating Provider provides services for treatment of an illness or injury which is allegedly the liability of a third party, you or your Eligible Dependent must agree in writing to hold any recovery in trust for the Participating Provider up to the Reasonable Cash Value of the Benefits. The Participating Provider may require that you or your Eligible Dependent sign an agreement guaranteeing the provider's right to reimbursement before providing services.
2. The Participating Provider is entitled to full reimbursement for the Reasonable Cash Value of the Benefits provided from the proceeds of any recovery you or your Eligible Dependent receive from or on behalf of the third party. This is so regardless of whether:
  - a. the recovery is the result of a court judgment, arbitration award, compromise settlement or any other arrangement;
  - b. the third party or the third party's insurer admits liability; or
  - c. the dental care services are itemized or expressly excluded in the third party recovery.
3. A proportionate share of the reasonable expenses of obtaining a recovery, such as attorney fees and court costs, may be deducted from the amount to be reimbursed to the Participating Provider.

## **MOTOR VEHICLE COVERAGE**

In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage. Benefits for dental care are excluded under this Policy to the extent that you or your Eligible Dependent are able to or are entitled to recover from motor vehicle insurance, but we will provide Benefits for Covered Services over the amount covered by motor vehicle insurance.

The following rules will apply to motor vehicle insurance coverage:

1. If a Participating Provider provides services for treatment of an injury arising out of a motor vehicle accident and motor vehicle insurance has not yet paid, you or your Eligible Dependent must agree in writing:
  - a. to give the Participating Provider information about any motor vehicle insurance coverage which may be available to you or your Eligible Dependent; and
  - b. to hold the proceeds of any recovery from motor vehicle insurance in trust for the Participating Provider and reimburse the Participating Provider as provided below.
2. The Participating Provider is entitled to reimbursement in the amount of the Reasonable Cash Value of the Benefits provided out of any subsequent motor vehicle insurance recovery or payment made to or on behalf of you or your Eligible Dependent, whether such recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage.
3. You or your Eligible Dependent who was involved in a motor vehicle accident may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the "Third Party Liability" section will apply.

## **GENERAL PROVISIONS**

### **Eligibility**

To establish initial eligibility, the applicant must complete our application form and be accepted by us for coverage under this Policy.

### **Policy Effective Date**

This Policy will go into effect at 12:01 a.m. at your place of residence on the Effective Date shown on the Policy Schedule. The Effective Date is the first of the month following or coinciding with the date we receive your application. In no event may the Effective Date of this Policy be back-dated.

### **Premium**

Premium for each Insured and Eligible Dependent shall be due on the first day of each month or quarter for which coverage is to be effective. If selected on the application, premium may be paid in advance on a quarterly basis. Such prepayment does not guarantee that the premium rate will remain unchanged for that prepaid period. The Insured agrees to pay us the total premium for all Members covered by this Policy on or before the date it becomes due. No person shall be entitled to any Benefits of this Policy during any calendar month for which payment of the premium has not been made. If premium is more than 31 days past due, this Policy will terminate as of the last day through which the premium was paid.

If the Insured has elected prepayment on a quarterly basis, and a revised premium rate is to become effective at the beginning of a period for which the Insured has already paid, the next quarterly billing will include an adjustment for a revised premium.

### **Grace Period**

A grace period will apply to payment of premiums (except the initial premium). This grace period means that if you pay your premiums within 31 days after they are due, your coverage remains continuously in force. If premium is more than 31 days past due, this Policy will terminate as of the last day through which the premium was paid.

### **Renewal**

This Policy will automatically be renewed annually unless we choose to change the rates, Benefits or any other Policy provisions. If there is a change in rates, Benefits or Policy provisions, you will be given written notice 30 days prior to the date of the change. You may reject such change by providing written notice to us 15 days prior to the date such change is due to take place. If we do not receive any notice of rejection, the Policy will be renewed annually from that time forward.

### **Additions to Coverage**

After the Effective Date, any child born to the Insured or placed in the Insured's custody pending adoption will be covered retroactively to the date of birth or placement if we receive the application for coverage within 31 days from the date of birth or date of placement.

### **Transfer of Coverage for a Dependent Child at Age 26**

Except as specified in the General Provisions, this Policy will automatically terminate for any Dependent Child on the first day of the month following their 26<sup>th</sup> birthday, and the Dependent Child will be notified of the option to continue coverage under their own Policy with us as the Insured.

### **Continuation of Coverage**

In the event that an Eligible Dependent loses their eligibility for coverage under this Policy due to death of the Insured or divorce of the Insured, such Eligible Dependent may continue coverage under this Policy. Dependents must continue to meet the eligibility requirements specified in the Definitions section of this Policy.

**Recovery of Benefits Provided By Mistake**

If a Participating Provider provides dental services to you or your Eligible Dependent for which you or your Eligible Dependent is not entitled, or if Benefits are provided to a person who is not eligible for Benefits under this Policy, the Participating Provider has the right to recover the Reasonable Cash Value of the Benefits provided from the Insured, the person to whom Benefits were provided, or from anyone else who benefited from the payment.

**Dental Care Responsibility**

All dental services are provided by facilities and professionals who are neither employees nor agents of LifeMap Assurance Company. Providers are responsible for the quality of care they render.

**Delayed Services Due to Circumstances Beyond Control**

When circumstances caused by an act of God or other causes beyond the control of a Participating Provider delay or prevent dental services under this Policy, neither we nor the Participating Provider will be liable for damage to you or your Eligible Dependent which results from such delay or failure to provide dental services.

## WHEN COVERAGE ENDS

### **Nonpayment of Premium**

If you fail to make required timely premium payments, your coverage will end for you and all Eligible Dependents. See PREMIUM above.

**NOTE: If coverage terminates because of non-payment of premium, the terminated Member will not be eligible again for coverage under this Policy for one full year after the Member's coverage is terminated.**

### **Termination by You**

You have the right to terminate this coverage on the last day of any month by providing us with 30 days prior written notice. Any payments made to us for coverage after the termination date will be refunded to the Insured. Termination of coverage will occur at the end of the month and no partial month refunds will be issued.

**NOTE: If you voluntarily terminate coverage for yourself or a dependent, the terminated Member will not be eligible again for coverage under this Policy for one full year after the Member's coverage is terminated.**

### **Termination by Us**

We may cancel this Policy on the last day of a month for any reason unless prohibited by law. Written notice will be provided 30 days prior to the date of termination stating the reason for the termination. We will provide Benefits for Covered Services performed prior to the date of termination. Your obligation to pay any premiums due shall survive termination. We will terminate coverage for a Member at the end of the same calendar month when the Member ceases to satisfy the requirements for Insured or Eligible Dependent.

### **Fraud or Misrepresentation**

A Member's coverage may be terminated for fraud or deception in applying for or using this Policy. It may also be terminated if the Member knowingly permitted fraud or deception by another. Termination for fraud or deception will be effective upon mailing of written notice by us to the Insured at the address shown on the application.

If this Policy terminates for an Insured, it will also terminate for the Insured's Eligible Dependents.

### **Cessation of Benefits Upon Policy Termination**

No person shall have or acquire a vested right to receive Benefits after the date this Policy is terminated. Termination of coverage under this Policy as to an individual Insured or Eligible Dependent for any reason shall completely end all obligations we have to provide the Member with Benefits on account of the services or supplies received after the date of termination whether or not the Member may then be receiving treatment, unless otherwise specified, or may thereafter be in need of treatment, for any illness, injury, or physical disability incurred or treated before or while this Policy was in effect.



## **CONTRACT PROVISIONS**

### **Entire Contract; Changes**

This Policy, including the application and any riders, endorsements or amendments, is the entire contract of insurance. No change in this Policy will be valid unless approved by an officer of LifeMap Assurance Company. Such approval must be attached to this Policy. No agent has the authority to change this Policy or waive any of its provisions.

### **Incontestability**

In the absence of fraud, after coverage has been in force for two years during the lifetime of the person, no misstatement made in the application by you or an Eligible Dependent will be used to void this Policy or deny Benefits.

### **Legal Actions**

No legal action may be brought to recover on this Policy until 60 days after proof of loss has been furnished. No action may be brought after 3 years from the time written proof of loss is required to be furnished.

### **Misstatement of Age**

If a Member's age has been misstated:

1. if premiums applicable to you are based on age and you have misstated your age, there will be a fair adjustment of premiums based on your true age; and
2. the benefits available under this Policy will be based on the benefits the premium would have purchased at the person's correct age.

### **Conformity With State Statutes**

If any provision of this Policy is in conflict with the statutes of the State of Washington on the Effective Date of this Policy, such provision is amended to conform to the minimum requirements of such statute.

## **CLAIMS FOR REIMBURSEMENT OF EMERGENCY TREATMENT**

### **Notice of Claim**

If, in the event of a Dental Emergency, the Member uses a nonparticipating dentist, claims for benefits under this Policy must be presented to Willamette Dental Group in writing within 6 months of the date of service.

### **Proof of Loss**

The written request must include the following information: the Member's name, address, identification number; the nature of the emergency; and an itemized statement from the dentist for their services. Additional information, including X-rays and other data, may be requested by the Willamette Dental Group to process the request.

All claims should be sent to the address below:

Willamette Dental Group  
Attn: Emergency Treatment Reimbursement Request  
6950 NE Campus Way  
Hillsboro, OR 97124-5611

### **Time Payment of Claims**

Losses covered by this Policy will be paid by as soon as we receive:

1. the bills which substantiate proof of loss; and
2. any information we request.

### **Payment of Claims**

We have the right to decide whether to pay benefits to you, to the provider of services, or to you and the provider of services jointly.

## **GRIEVANCES AND APPEALS**

### **Grievance Procedures - To be used for a Benefit or service concern or complaint.**

Most matters can be resolved with the Participating Provider's staff and Members are encouraged to first discuss matters regarding care and treatment with them. If the Member remains unsatisfied after discussion with the Participating Provider, grievance procedures are available for complaints pertaining to a denied Benefit or service.

A grievance is a written complaint expressing dissatisfaction with the denial of a requested Benefit or service. The Member should outline their concerns and specific request in writing. The Member may submit comments, documents, and other relevant information. Grievances must be submitted to the Participating Provider's Member Services Department within 180 days after the denial of Benefits or services.

The Member Services Department will review the grievance and all information submitted. You will be provided a written reply within 30 days of receipt. If additional time is needed, the Member Services Department will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

If the Benefit request involves:

1. **A preauthorization**, the Member Services Department will provide a written reply within 15 days of the receipt of the written grievance.
2. **Services deemed Experimental/Investigational**, the Member Services Department will provide a written reply within 20 working days of the receipt of the written grievance.
3. **Services not yet rendered for an alleged Dental Emergency**, the Member Services Department will provide a reply within 72 hours of the receipt of the written grievance.

If the grievance is denied, the written reply will include information about the basis for the decision and other disclosures as required under state and federal laws.

**All written Grievances should be sent to the address below:**

Willamette Dental Group  
Attn: Member Services  
6950 NE Campus Way  
Hillsboro, OR 97124-5611

### **Appeal Procedures - To be used for a billing or eligibility concern or complaint.**

If you or your Eligible Dependent have a concern regarding billing of premium or eligibility for Benefits, an appeal or request for review may be submitted (along with any additional information which would affect the situation) to us for consideration.

We will review the information submitted and you will be provided a written reply within 30 days after the appeal was received by us. If additional time is needed, we will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

**All written appeals should be sent to the address below:**

LifeMap Assurance Company  
Attn: [ Billing Supervisor ]  
P.O. Box 1271, M/S E8L  
Portland, OR 97207-1271