

SUMMARY OF BENEFITS COLUMBIA DENTAL PLAN CD-10



This dental plan offers services provided exclusively by Willamette Dental Group (WDG). WDG together with its affiliated companies is one of the largest managed care dental groups in the nation. With over 20 years experience in managed care, WDG will provide you with dental services for a minimal charge. This combined with Regence BlueShield's more than 60 years of experience, providing comprehensive health care to the community, adds up to an exceptional plan.

Dental offices are open 6 days a week, Monday through Saturday, from 7 a.m. to 6 p.m. Evening appointments are also available.

There are no deductibles and no annual plan maximum.

Per-Visit Copay

A \$10 per-visit copay is required each time a member visits a participating provider. Some services will require an additional copay as specified. See the brochure for additional benefits.

Service Copays

Preventive and Diagnostic Services

Fluoride treatments	paid in full after per-visit copay
Routine exams and cleanings	paid in full after per-visit copay
X-rays	paid in full after per-visit copay

Basic Services

Simple extractions	paid in full after per-visit copay
Fillings	paid in full after per-visit copay
Osseous (bone) surgery (per quadrant)	\$180
Root planing (per quadrant)	\$65
Root canals (per tooth)	
Anterior	\$60
Bicuspid	\$105
Molar	\$150

Major Services

Bridges (pontics - per tooth)	\$180
Crowns (per tooth)	\$180
Dentures (per upper/lower)	\$195

General Anesthesia administered for covered dental procedures when necessary because the member is under the age of seven, developmentally disabled, or physically handicapped.	\$75
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Nitrous Oxide (per visit)	\$20
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Temporomandibular Joint Disorder (TMJ) \$1,000 per calendar year to a lifetime maximum of \$5,000	benefits will be provided the same as any other condition
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Referrals: Referrals must be made by a Willamette Dental Provider. Services will be covered for those procedures authorized by the referring dentist.

Emergency Care: Emergency care is available at any time. During office hours, the usual per-visit copay applies. For after-hour emergencies, there is an additional \$25 copay.

Exclusions and Limitations to Coverage: The noncovered services and supplies include, but are not limited to: bleaching of a tooth; charges for dental services performed by anyone who is not a licensed dentist or licensed denturist; correction of malocclusion; preventive orthodontic procedures, including craniomandibular orthopedic treatment (except as specified), or other orthodontic treatment (unless selected as an option); dental services started prior to the date that the member became eligible for services under this plan or for items installed or delivered more than 30 days after coverage has been terminated; dentistry for cosmetic reasons; drugs or medicines (whether or not prescribed); full-mouth reconstruction; dental implants and associated procedures (including crowns over implants, attachment devices and their maintenance); habit-breaking or stress-breaking appliances; investigational services or supplies; hospitalization for dentistry.

This is a brief summary of benefits and exclusions; it is not a certificate of coverage. For full coverage provisions, including a description of limitations and exclusions, refer to your benefits brochure and the contract on file with your group. Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-800-458-3523 or visit our Web site at www.wa.regence.com and complete the Suggestion Box form located on the Contact page.

This plan is underwritten by Regence BlueShield of Seattle, Washington.