

PREPAID PLAN LIMITATIONS AND EXCLUSIONS

LIMITATIONS

A. GENERAL

Dental treatment must be received from MEMBER'S participating dental office unless specifically authorized in writing by PLAN.

Participating PROVIDERS shall have the right to discontinue further treatment of a MEMBER who continually fails to keep appointments or who fails to follow their prescribed course of treatment.

B. DIAGNOSTIC/PREVENTIVE

1. Routine and periodic examinations are limited to once every six (6) months.
2. Prophylaxis is limited to once every six (6) months.
3. Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one series of films in any twelve (12) consecutive month period.
4. Full mouth radiographs (x-rays) and Panorex are limited to once every three (3) years.
5. Fluoride treatment is limited to once every twelve (12) months.
6. Sealants are allowed in permanent first and second molars up to the age of sixteen (16).

C. RESTORATIVE/CROWNS

1. Space maintainers are allowed only for dependent children up to the age of sixteen (16).
2. Stainless steel crowns on permanent teeth are allowed up to the age of nineteen (19).
3. Temporary restorations, all adhesives (including amalgam bonding agents) liners and bases, impressions and local anesthesia are considered components of the fee for the completed restoration.
4. Benefits for the treatment of rampant caries are limited to the first seven (7) most severely decayed primary teeth, subject to all plan limitations. Rampant caries is defined as eight (8) or more decayed primary teeth.
5. Cast restorations and crowns are covered only when extensive coronal destruction is radiographically evident and tooth cannot be restored with an intracoronal restoration, unless tooth is diagnosed as having cracked tooth syndrome.
6. The use of noble and high noble metal for any restorative procedure will be charged to the MEMBER at the additional laboratory cost of the noble or high noble metal. Copayments do not include charges for gold or dental laboratory fees.

D. PROSTHODONTICS

1. Complete and/or partial denture relines are limited to one per denture during any twelve (12) month period.
2. Complete or partial upper and/or lower dentures are limited to the benefit level for a standard procedure. If a more personalized or specialized treatment (such as precision attachments, overlays, implants, personalization or characterization) is chosen by the MEMBER and the dentist, the MEMBER will be responsible for all additional charges.
3. A fixed bridge in any posterior quadrant, when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic, is considered elective. An alternate benefit for a partial denture would be allowed. See Alternate Benefit Provision, Section XVI.

E. PERIODONTAL

Periodontal Scaling and Root Planing are limited to four (4) quadrants per calendar year if periodontal disease is present. No more than two (2) quadrants per service date are allowed.

Osseous surgery is limited to four (4) quadrants per lifetime.

One treatment of Actisite for replacement of fiber material is allowed within ten (10) days of initial placement.

EXCLUSIONS

The following treatment or services are not covered.

1. Any procedure not specifically listed as a covered service.
2. Any dental treatment which, in the opinion of the attending dentist, is not necessary for the patient's dental health, will not produce a beneficial result, or has a poor prognosis.
3. Services for injuries or conditions for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, medical health insurance, Worker's Compensation or Employer's Liability Laws.
4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political subdivision, except as provided in Section XIII, Paragraph J of this Agreement.
5. Treatment rendered by a SPECIALIST if MEMBER is deemed unmanageable for treatment by any Network General Dentist, except for covered dependent children up to the age limit stated on Specialty Referral Exhibit D if specialty care is included.
6. Conditions resulting from disease or epidemic or injuries sustained as a result of a major disaster or war (declared or undeclared).
7. Dental procedures initiated prior to MEMBER'S eligibility under this benefit plan or started after MEMBER'S termination from the plan.
8. Services performed for cosmetic, elective, or aesthetic purposes, unless the policy includes a Cosmetic/Elective Benefit Rider (Exhibit E).
9. Dental laboratory fees including the cost of noble and high noble metal.
10. Services or supplies that do not meet accepted standards of dental practice, which are experimental in nature or are considered enhancements to standard dental care.
11. Implants and services incurred as part of implants, and fixed or removable prosthetics placed on implants.
12. Treatment related to temporomandibular joint syndrome (TMJ).
13. Appliances, restorations, or procedures to:
 - alter vertical dimension,
 - restore or maintain occlusion,
 - splint or stabilize teeth for periodontic reasons,
 - replace tooth structure lost as a result of abrasion, erosion, or attrition, or
 - treat bruxism (nightguards, harmful habit and thumbsucking devices).
14. Treatment and/or services (including biopsy) for malignancies, cysts, neoplasms, or congenital or developmental malformations, including but not limited to, cleft palate, enamel hypoplasia, fluorosis, anodontia, supernumerary or impacted teeth other than third molars.
15. General anesthesia, analgesia (including nitrous oxide), sedation, and prescription drugs.
16. Any inpatient/outpatient hospital or surgicenter charges of any kind including physician charges, prescriptions or medication.
17. Treatment for crown exposure, ligation, and crown lengthening.
18. Replacement of an appliance or fixed or removable prosthetic with a like appliance or prosthetic unless the appliance or prosthetic is at least 5 years old and cannot be made usable. Replacement of crowns unless existing crown is more than five (5) years old.
19. Replacement of a lost, stolen, or missing appliance or prosthetic device, glasses, or contacts.
20. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction (six or more units of crown and/or bridgework in one arch or more than ten units total).
21. Resectioning of the bone and surgeries involving repositioning of the teeth or tooth implantation, re-implantation or transplantation.
22. Oral surgery for fractures or dislocations of the jaw, resectioning of the bone, repositioning of the teeth or bone implantation or transplantation, salivary gland, duct or sinus. Orthognathic surgery and extractions for orthodontic purposes.
23. Elective oral surgery, including the extraction of non-pathologic, asymptomatic teeth, overretained deciduous teeth, and deciduous teeth which appear to be at or near exfoliation.
24. Orthodontic treatment unless specifically included. Under any applicable orthodontic benefits, treatment plans started before MEMBER enrolled with the PLAN are not covered.