

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

EXCLUSIONS – Only American Dental Association procedure codes are covered. Exclusion and limitations may differ by state as specified below. **Except as specifically provided in this Policy, Schedules of Benefits, Riders, no coverage will be provided for services, supplies or charges that are:**

1. Specifically listed on the Schedule of Benefits as “Not Covered.”
2. Started prior to the Member’s Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics).
3. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
4. The responsibility of Workers’ Compensation or employer’s liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company’s benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers’ Compensation or employer’s liability insurance shall be excluded from this Plan.

For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers’ Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.

5. For prescription and non-prescription drugs, vitamins or dietary supplements.
For Group Policies issued and delivered in Arizona this exclusion does not apply.
6. Cosmetic in nature as determined by the Company (for example but not limitation, restorations, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
7. For services, appliances, and restorations that alter the vertical dimension (to restore tooth structure lost from attrition, erosion or abrasion).
8. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
9. For congenital mouth malformations or skeletal imbalances (for example but not limitation, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

For Group Policies issued and delivered in Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Indiana, Missouri and Virginia, this exclusion shall not apply to newly born children of Members.

For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

10. For any surgery, placement, restoration, maintenance and removal related to implants.
11. Diagnostic services and treatment of jaw joint problems by any method. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
12. For treatment of fractures and dislocations of the jaw.
13. For treatment of malignancies or neoplasms.

14. For which in the absence of insurance the Member would incur no charge.
15. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
16. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
17. For treatment and appliances for bruxism (night grinding of teeth).
18. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
19. For incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary restorations.
20. For procedures that are:
 - part of a service but are reported as separate services; or
 - reported in a treatment sequence that is not appropriate; or
 - misreported or that represent a procedure other than the one reported.
21. For specialized procedures and techniques (for example but not limitation, intentional root canal treatment).
22. Fees for broken appointments.
23. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
24. Space maintainers, posterior resins and prefabricated stainless steel crowns.

AGES 0-15 LIMITATIONS – Only the following services are covered; they are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches the age of 16.

1. Full mouth x-rays – not covered for patients under age five (5). Ages five (5) through fifteen (15), covered if supported by FDA guidelines.
2. Occlusal Films – two (2) per twenty-four (24) months for patients age seven (7) and younger.
3. Bitewing x-rays– one (1) set of two films per six (6) months.
3. Oral Evaluations:
 - Periodic – one (1) per six (6) months.
 - Comprehensive – one (1) per thirty-six (36) months unless there is a significant change in health status.
 - Limited problem focused– two (2) per twelve (12) months.
 - Evaluation under three years old – one (1) per lifetime.
4. Prophylaxis – one (1) per six (6) months.
5. Fluoride varnish – one (1) per six (6) months.
6. Sealants – one (1) per tooth per three (3) years through age fifteen (15) on permanent 1st and 2nd molars.
7. Replacement of anterior resin-based composite restorations and posterior amalgam restorations – one (1) of these restorations per tooth, per surface, per thirty-six (36) months when they are not and cannot be made serviceable.
8. Composite resin crown – one (1) per tooth per lifetime, anterior only.
9. Pulpotomy, pulpal debridement, and root canal therapy – one (1) tooth per lifetime.
10. Pulpal therapy – covered through age five (5) on primary anteriors, and through age eleven (11) on primary posteriors.
11. Palliative Treatment – two (2) per twelve (12) months.

12. Periapical X-rays – four (4) per twelve (12) months, and only when taken with a problem-focused evaluation or palliative emergency treatment.
13. Sedation – covered for patients twelve (12) and under when medically necessary.

AGES 16-49 LIMITATIONS – Only the following services are covered; they are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches the age of 50.

1. Full mouth x-rays – one (1) per lifetime, new patients only.
2. Bitewing x-rays (2, 3 or 4 films) – one (1) set per twenty-four (24) months ages sixteen (16) through twenty-nine (29) and one (1) set per three (3) years for ages thirty (30) and through forty-nine (49).
3. Oral Evaluations:
 - Periodic – one (1) per twelve (12) months.
 - Comprehensive – one (1) per three (3) years unless significant change in health status.
 - Limited problem focused– two (2) per twelve (12) months.
4. Prophylaxis – one (1) per twelve (12) months.
5. Fluoride varnish – one (1) per twelve (12) months.
6. Replacement of anterior resin-based composite restorations and posterior amalgam restorations – one (1) of these restorations per tooth, per surface, per three (3) years when they are not and cannot be made serviceable.
7. pulpal debridement, and root canal therapy – one (1) tooth per lifetime.
8. Palliative Treatment – two (2) per twelve (12) months.
9. Periapical X-rays – four (4) per twelve (12) months, and only when taken with a problem-focused evaluation or palliative emergency treatment.

AGES 50+ LIMITATIONS – Only the following services are covered; they are limited as detailed below.

1. Full mouth x-rays – one (1) per lifetime, new patients only.
2. Bitewing x-rays (2, 3 or 4 films) – one (1) set per thirty-six (36) months.
3. Oral Evaluations:
 - Periodic – one (1) per twelve (12) months.
 - Comprehensive – one (1) per three (3) years unless significant change in health status.
 - Limited problem focused– one (1) per twelve (12) months.
4. Prophylaxis – one (1) per twelve (12) months.
5. Fluoride varnish – one (1) per twelve (12) months.
6. Replacement of anterior resin-based composite restorations and posterior amalgam restorations – one (1) of these restorations per tooth, per surface, per three (3) years when they are not and cannot be made serviceable.
7. Composite resin crown - one (1) per tooth per lifetime, anterior only.
8. pulpal debridement, and root canal therapy – one (1) tooth per lifetime.
9. Palliative Treatment – one (1) per twelve (12) months.
10. Periapical X-rays – four (4) per twelve (12) months, and only when taken with a problem-focused evaluation or palliative emergency treatment.
11. Denture adjustments – one (1) per arch, per two (2) years, integral within six (6) months of insertion with the same dentist.
12. Denture repairs – one (1) per tooth/arch per three (3) years.

