EXCLUSIONS AND LIMITATIONS

EXCLUSIONS (SERVICES NOT COVERED UNDER THE PLAN):

1. Services required because of, or in connection with, acts of war, declared or undeclared.
2. Services or supplies paid for or provided because of services in the armed forces of any government.
3. Dental services or supplies furnished after the date coverage ends are not a covered benefit, any costs becoming the responsibility of the participant. However, the following are exceptions under "work in progress": completion of dentures, crowns, inlays or bridges when the dentist took the impressions and/or prepared the teeth while the participant was covered; and/or root canal therapy if the dentist opened the tooth while the participant was covered; and these services are completed within 30 days of the end of coverage.
4. The charge for a broken appointment is not a benefit and shall be the responsibility of the patient.
5. Charges for services or supplies that are principally cosmetic in nature, including, but not limited to, bleaching, veneers facings, crowns, charges for personalization or characterization of crowns, bridges and/or dentures.
6. Prescription drugs, vitamins or dietary supplements are not a covered benefit.
7. Duplicate dentures, prosthetic devices or any other duplicate appliances.
8. General anesthesia is not a covered benefit, unless administered in conjunction with oral surgery as listed in the schedule of dental benefits. If the attending dentist determines general anesthesia is medically necessary in connection with any other covered service, reimbursement should be sought from the medical plan.
9 Training and/or appliance to correct harmful habits, including, but not limited to muscle training therapy (myofunctional therapy).
10. Hospitalization and services rendered in a hospital are not a covered service. If the attending dentist determines hospitalization is medically necessary in connection with a covered service, reimbursement should be sought from the medical plan.
11. Implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.
12. Services paid for under no-fault laws.
13. Expenses for replacement or repair of an orthodontic appliance.
14. Periodontal splinting (connecting) teeth by any method including, but not limited to, crown, fillings, appliances or any other method that splints or connects teeth together.
15. Services and/or appliances that alter the vertical dimension-change the way the teeth meet (the bite)-including full mouth rehabilitation (crowning all or almost all the teeth), splinting (connecting) teeth with crowns, fillings, appliances or other methods.
16. Replacement of existing dentures that are, or can be made, satisfactory.
17. Charges resulting from voluntary self-inflicted injury or illness, whether the patient is sane or insane.
18. The costs for any services that are necessary because the participant failed to cooperate and/or maintain good oral hygiene are the responsibility of the participant and are not a covered benefit.
19. Dental procedures performed before the effective date of dental eligibility are the responsibility of the patient.
20. Services or supplies that are not necessary, according to accepted standards or dental practice, or are not recommended nor approved by the Fund Dental Consultant, or are experimental in nature.

21. Diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.
22. Transportation is not a covered benefit.
23. Services that are covered by any workers' compensation laws or employers' liability laws, or services that an employer is required by law to furnish in whole or in part.
24. Orthognathic or maxillo-facial surgery, treatment of malignancies or oral surgery requiring the setting of fractures or dislocations.
25. Congenital or developmental malformations or hormonal imbalances.
26. Any treatment related to periodontal disease, except those services listed in the dental reimbursement schedule.
27. Charges for services/conditions which are not listed in this packet, unless services/conditions are substantially similar to the service/conditions which are covered as determined by this Plan.

LIMITATIONS:

1. Dollar Limitations/Plan Maximum (not including orthodontics) is as follows - Maximum allowance payable by the plan for dental services is $1,500.00 per eligible family member, per calendar year. This allowance does not carry over per year and is not transferable between family members.
2. If a condition can be corrected or treated by professionally acceptable service at a lower cost, the plan covers only the lower cost service. If a participant chooses a more costly service or treatment, he or she is responsible for the difference in cost. Alternate treatment may include, but is not limited to, use of gold, crowns, fixed bridges, dentures and partial dentures.
3. Services are limited to those listed in the plan document. If a service is not listed, it is not a covered benefit.
4. Dentures, Full and Partial are covered once in a five year period. Partial to Full Dentures will be limited to a 3 year replacement period when approved by the Dental Consultant as being dentally necessary.
5. Crowns and Bridges are covered once in a five year period. Single crown replacement as part of fixed bridge will be limited to a 3 year replacement period when approved by the Dental Consultant as being dentally necessary.
6. Recall exams are limited to one every six months.
7. Prophylaxis is limited to one every six months.
8. Full Mount Light Scaling is limited to one every six months.
9. Prophylaxis and Full Mouth Light Scaling will not be covered unless 3 months have elapsed between the two procedures
10. Periodontal Scaling and Root Planning, per quadrant is allowed once every 3 years.
11. Periodontal Prophy is limited to one every six months following periodontal surgery and performed by a Periodontist.
12. Fluoride treatments are limited to one treatment every six months for dependent children 14 years of age and under.
13. Replacement of sealant(s) and restoration(s) will not be covered unless the original restoration(s) or sealant(s) was placed 24 months prior to replacement.