LIMITATIONS AND EXCLUSIONS

Limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D1208, D2999) – four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays – one (1) set in any three (3) year period.
- Bitewing x-rays – two (2) sets in any twelve (12) month period.
- Panoramic x-rays – one (1) in any three (3) year period.
- Sealants – limited to permanent teeth, up to the 16th birthday – one (1) per tooth in any three (3) year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
- Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
- Cleft palate treatment, cancer treatment, and biopsies may also fall under medical services.
- Treatment of fractures may also fall under medical services where the treatment is due to an accident or injury to the mouth.
- Inpatient hospital services may also fall under medical services and be covered through the separate medical services contract depending on the treatment needed and the nature of the injury.
- Emergency dental services when more than fifty (50) miles from the Primary Care Dentist's office – limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by MDG – limited to the benefit for palliative treatment (D9110) only.
- Reline of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Rebase of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Second Opinion Consultation – when approved by the Plan, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan.

Exclusions – We will not cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a) congenitally missing or (b) supernumerary teeth.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the Participating Dentist is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the Primary Care Dentist, or (b) treatment by a specialist without a referral from the Primary Care Dentist and Plan approval.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

- Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's selected and assigned Primary Care Dentist, unless we had provided written authorization.

- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

- Treatment which requires the services of a Prosthodontist.

- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th (eighth) birthday.

- Consultations for non-covered services.

- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.)

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)

- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, or fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the Plan as Emergency Dental Services.

- Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the Plan as Emergency Dental Services.

- Orthodontic treatment started by a non-participating dentist while the Member is covered under this Plan. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Extractions performed solely to facilitate orthodontic treatment.

- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.

- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.

- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.

- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.