

## Limitations

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1. One (1) intraoral, complete series of x-rays (full mouth series) or panoramic radiographic image is covered once each thirty-six (36) month period;
2. One (1) series of bitewing radiographic images are covered once each six (6) month period;
3. Two (2) prophylaxis (routine cleaning) or periodontal maintenance (after active periodontal treatment) are covered in a twelve (12) month period. Two (2) additional prophylaxis in a twelve (12) month period are available at the member co-payment listed on the Plan's Schedule of Benefits;
4. Two (2) fluoride treatments are covered in a twelve (12) month period;
5. Sealants are covered on first and second permanent molars with no caries (decay) only for dependent children under age 14. Limited to once per tooth per thirty-six (36) month period;
6. Replacement of crowns, labial veneers or fixed partial dentures (bridgework), per unit, are limited to once every 5 year period;
7. An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. Exception: Implant supported prosthetics are listed in this Plan's Schedule of Benefits at the actual member co-payment amounts. No additional charge is allowable for noble, high noble or titanium associated with implant supported prosthetics;
8. An additional charge, not to exceed \$75 per unit, will be applied to crowns and fixed partial dentures (bridges) for porcelain or resin on molar teeth;
9. Cases involving seven (7) or more crowns and/or fixed partial denture (bridge) units in the same treatment plan required an additional \$125 member co-payment per unit in addition to the specified member co-payment amount on the Plan's Schedule of Benefits;
10. The member co-payments for endodontic procedures (root canals) do not include the cost of the final restoration;
11. All surgical periodontal services are limited to once every thirty-six (36) month period;
12. One (1) bone replacement graft per lifetime;
13. Periodontal scaling and root planing (deep cleaning) is limited to once per quadrant/site in a twenty-four (24) month period;
14. Full mouth debridement is limited to once in a 24 month period;
15. Replacement of complete and partial dentures is limited to once every five (5) year period only if the existing appliance is unsatisfactory and cannot be made satisfactory as determined by the treating LIBERTY Dental Plan General Dentist;
16. Complete denture and partial denture adjustments are included as part of the denture procedure for twelve (12) months following initial insertion. Following the initial twelve (12) months, adjustments are covered once in a twenty-four (24) month period;
17. Complete denture and partial denture relines or rebases are included as part of the denture procedure for twelve (12) months following initial insertion. Following the initial twelve (12) months, relines or rebases are covered once in a twenty-four (24) month period;
18. Tissue conditioning is included as part of the denture procedure for twelve (12) months following initial insertion. Following the initial twelve (12) months, tissue conditioning is covered once in a twenty-four (24) month period;

19. Surgical placement of implant body limited to one (1) per site per lifetime;
20. Deep sedation/general anesthesia and intravenous conscious sedation/analgesia are covered benefits only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic is contraindicated. Deep sedation/general anesthesia and intravenous conscious sedation/analgesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for this type of anesthesia;
21. Pediatric referrals, if authorized by LIBERTY Dental Plan, are covered only for dependent children under the age of eight (8) unless the child qualifies under the American with Disabilities Act (ADA);
22. All services must be provided by the member's assigned LIBERTY Dental Plan General Dentist unless authorized by LIBERTY Dental Plan.

## Exclusions

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1. Services performed by any dentist not contracted with LIBERTY Dental Plan without prior approval by LIBERTY Dental Plan (except for out-of-area emergency services). This includes services performed by a General Dentist or a Dental Specialist;
2. The removal of asymptomatic third molars (wisdom teeth) is not a covered benefit unless pathology (disease) exists. Removal is available, however, from your contracted LIBERTY Dental Plan General Dentist or Dental Specialist at a 25% discount based on the dentist's Usual and Customary fees where available;
3. Extractions solely for the purpose of orthodontia;
4. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress and full and partial dentures for which an impression has been taken;
5. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the LIBERTY Dental Plan assigned General Dentist or LIBERTY Dental Plan's Dental Director;
6. Orthognathic surgery;
7. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications;
8. Replacement of dentures, crowns, appliances or bridgework that have been lost or stolen;
9. Treatment of malignancies, cysts or neoplasm unless specifically listed as a covered benefit on this Plan's Schedule of Benefits;
10. Laboratory fees;
11. Procedures, appliances or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital, developmental or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on the Plan's Schedule of Benefits;

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12. Dental services provided for or paid by a federal or state government agency or authority, political subdivision or other public program other than Medicaid or Medicare;
13. Dental services required while serving in the Armed Forces of any country or international authority;
14. Dental services considered to be experimental in nature;
15. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member;
16. Treatment or service replacing tooth structure lost from abrasion, attrition, erosion or abfraction;
17. Orthodontic treatment unless offered and issued by rider;
18. Any procedure not specifically listed as a Plan benefit. Such procedures, however, are available from your contracted LIBERTY Dental Plan General Dentist or Dental Specialist at a 25% discount based on the dentist's Usual and Customary fees where available.