

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

In addition to items identified as NOT COVERED in the Benefits Schedule, this section tells you what services or supplies are excluded from coverage under this Plan.

- Dental services for aesthetics only and/or cosmetic dental care unless otherwise listed as a covered benefit.
- General anesthesia, intravenous and inhalation sedation, prescription drugs for anesthesia, and the services of a special anesthesiologist unless otherwise listed as a covered benefit.
- Dental conditions arising out of and due to a Member's employment or for which the Member is entitled to Workers' Compensation benefits.
- Hospital and medical facility charges of any kind.
- Services of any kind provided in the home.
- Ambulance services.
- Durable Medical Equipment.
- Mental Health services.
- Chemical Dependency services
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist unless otherwise listed as a Covered Benefit.
- Treatment started before the member was eligible, or after the member was no longer eligible.
- Any services performed outside of your assigned dental office, unless expressly authorized by Liberty Dental Plan, or unless as outlined and covered as emergency dental care.
- Charges from a medical doctor, doctor of osteopathic medicine and/or other medical professional except for dental services otherwise covered herein.
- Treatment of fractures or dislocations.
- Replacement of lost or stolen dentures, partials or other appliances (e.g. crowns, bridges, full or partial dentures).
- Services which are normally reimbursed by a third party or liability insurance and/or under the medical portion of a group health plan.
- Dental procedures for which treatment was started prior to the time Member became eligible for benefits.
- Procedures, appliances, restorations or other treatment to correct congenital or developmental malformations.
- Treatment and/or removal of: (a) malignancies; (b) cysts or benign tumors not within the scope of usual dental care; (c) odontogenic cysts exceeding 1.25 cm in diameter.
- Drugs/ medications not normally supplied or prescribed by a dental office.
- Any treatment which, on the opinion of LIBERTY's Dental Director, is not necessary for the Member's dental health.
- Replacement of an existing bridge, partial or denture which, in the opinion of LIBERTY's Dental Director, is satisfactory or that can be made satisfactory.
- Orthognathic surgery.

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- Implants or any prosthesis attached to or dependent upon an implant unless otherwise listed as a covered benefit on the Benefits Schedule.
- Any experimental, investigational or exotic procedure not approved by the ADA Council on Dental Therapeutics.
- Treatment to alter vertical dimension or to restore occlusion, unless dentures are involved.
- Treatment or therapy for Temporo Mandibular Joint (TMJ) problems including, but not limited to, assessment beyond that customarily provided in a general dental practice.
- Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional(e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones) unless otherwise covered as an orthodontic benefit.
- Appliances needed to increase vertical dimension or restore occlusion.
- Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension or restoring occlusion.
- Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years.
- Treatment or service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction.
- Expense or charge incurred by a Member confined to an institution of any kind.
- Cases in which, in the reasonable professional judgment LIBERTY's Dental Director, a satisfactory result cannot be obtained.
- Replacement of long-standing missing tooth/teeth in an otherwise stable dentition.
- Orthodontic services unless otherwise listed as a covered benefit.
- Care related to the bite, alignment of teeth, or bite correction.
- Charges for specialized techniques involving precision attachments, personalization or characterization of a temporary or permanent prosthesis.
- Any service not specifically listed as a Covered Benefit on the Benefits Schedule.

LIMITATIONS

In addition to the limitations of coverage identified in the Benefits Schedule, this section tells you when LIBERTY's duty to provide or arrange for services is limited.

- LIBERTY will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by the following:
 - Natural disaster.
 - War.
 - Riot.
 - Civil insurrection.
 - Epidemic.
 - Or any other emergency beyond LIBERTY's control.
- Benefits in excess of the yearly or lifetime maximum benefits. Please see the Benefit Schedule for Calendar Year maximum benefits and lifetime maximum benefit limitations on certain services.
- Prophylaxis is limited to one treatment each (6) month period (includes periodontal maintenance following active therapy). Unless optional one treatment per four (4) month rider is purchased.
- Oral evaluation is limited to two in each (12) month period.
- Oral hygiene instruction is limited to one per twenty-four (24) month period.
- Fluoride treatment is limited to one treatment every six (6) month period.
- Crowns, bridges and dentures may not be replaced within five (5) years from the initial placement.
- Partial dentures are not to be replaced within five (5) years of the initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Denture relines are limited to one per denture during any twelve (12) consecutive months.
- Covered charge for both a temporary and a permanent prosthesis will be limited to the charge for a permanent prosthesis only.
- Charges for adjustment of a prosthesis will be limited to one in a six (6) month period.
- Periodontal treatments are limited to one time per quadrant during any twenty-four (24) consecutive months.
- Fill mouth debridement (gross scale) is limited to one treatment in any thirty-six (36) consecutive month period.
- Osseous surgery is limited to one treatment in any five (5) year period.
- Crowns will be covered only if, in the opinion of LIBERTY's Dental Director, there is not enough retentive quality left in the tooth to hold a filling.
- Bitewing x-rays are limited to not more than one series of four films in any six (6) month period.
- Full mouth x-rays and/or panoramic type films are limited to one set every thirty-six (36) consecutive months. Sealant benefits include the application of sealants only to permanent first and second molars with no decay for dependent children only up to the age of 14. Sealant benefits Limited to once per tooth in any 36 consecutive month period.
- Periodontal scaling and root planning limited to once each quadrant in any 24 consecutive month period.
- Periodontal surgical procedures are limited to once per quadrant in any 36 consecutive month period.
- Crowns are covered only if the tooth cannot be restored by a filling.
- If LIBERTY determines that more than one procedure could be performed to correct a dental condition, the covered benefit will be the least expensive of the procedures that would provide professionally acceptable results.