

Exclusions and Limitations

1. Any dental services which were not rendered, prescribed, arranged, or approved by a participating dentist, except in cases of out-of-area dental emergency.
2. A service not furnished by a Dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.
3. Treatment of a disease, defect, or injury covered by a major medical plan, Worker's Compensation Law, occupational disease law, or similar legislation.
4. General anesthesia, analgesia and any service rendered in a hospital environment.
5. Any dental procedures which are undertaken primarily for cosmetic reasons, or dental care to treat accidental injuries, congenital or developmental malformations.
6. Restorations, crowns, or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.
7. Services which were started prior to the person becoming covered under the plan.
8. Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
9. Replacement of any existing crown , bridge or denture which can be made serviceable according to common dental standards.
10. Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; lengthen crowns, or restore occlusion.
11. General dental care is only covered at the office of CapDent general dentists. Treatment of unmanageable children by general dentists or pedodontists will not be covered. An attempt will be made to treat all patients. However, if any patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents of the patient.
12. Services not listed in the proposed Schedule of Benefits are not covered.

THE FOLLOWING LIMITATIONS APPLY TO ALL DENTCARE DESIGNED DENTAL PLANS:

Oral Exams, bitewing x-rays, prophylaxes, scalings, fluoride treatments	Once every 6 months
Full Mouth and panoramic x-rays	Once every 36 months
Crowns, bridges, dentures and periodontal surgery	Once every 60 months
Orthodontic treatment of Class II/III malocclusions	One 24 month case

Certain other procedures may have age limitations. A list of such services is available upon request