CIGNA DHMO K1-09 Exclusions And Limitations

LIMITATIONS ON COVERED SERVICES
Listed below are limitations on services covered by your Dental Plan:

1. **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

2. **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's seventh birthday. Effective on your child's seventh birthday, dental services must be obtained from a Network general Dentist however, exceptions for medical reasons may be considered on an individual basis.

3. **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

4. **Periodontal** (gum tissue and supporting bone) **Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

GENERAL LIMITATIONS - DENTAL BENEFITS
No payment will be made for expenses incurred or services received:

1 For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit;

2 for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated run by the United States Government or by a state or municipal government if the person had no insurance;

3 To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;

4 For the charges which the person is not legally required to pay;

5 For charges which would not have been made of the person had no insurance;

6 Due to injuries which are intentionally self-inflicted.

SERVICES NOT COVERED UNDER YOUR DENTAL PLAN
Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

1. services not listed on the Patient Charge Schedule.

2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in Section IV.F).

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

5. services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.

7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

8. prescription drugs.

9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

11. services associated with the placement, repair or prosthodontic restoration of a dental implant, or any other services related to implants.

12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..

13. procedures or appliances for minor tooth guidance or to control harmful habits.

14. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)

15. services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)

17. consultations and/or evaluations associated with services that are not covered.

18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.

19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.

20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

21. services performed by a prosthodontist.

22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.

24. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

25. the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

26. services to correct congenital malformations, including the replacement of congenitally missing teeth.

27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule number ends in "-04" or a higher number, there is no coverage for the following:

1. crowns and bridges used solely for splinting.

2. resin bonded retainers and associated pontics.

OTHER SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Surgical placement of a dental implant, repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.

the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress of the effective date of your CIGNA Dental coverage. (California and Texas residents; Preexisting conditions, including the completion of crowns, bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your coverage are not excluded, if otherwise covered under your Patient Charge Schedule.)

the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (Including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

crowns, bridges and/or implant supported prosthesis used solely for splinting.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

The term "DHMO" is used to refer to product design that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans with open-access features.