Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). However, for dependent children, benefits will include coverage of an injury or sickness including the Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including cleft lip and cleft palate, including the correction of occlusion (malocclusion) caused by the congenital defect or birth anomaly. Benefits are the same for congenital defects or anomalies, including individuals born with cleft lip or cleft palate, as are provided for other dental conditions that are covered by the plan.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment, except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time or transportation costs.
- temporary, transitional or interim dental services.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
    - Yourself or Your employer;
    - a person who lives in the Insured Person's home, or that person's employer;
    - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- for charges which the person is not legally required to pay;
- for charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule, except in the case of Emergency Services;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Any services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this Plan.