The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GUARDIAN PREVENTIVE FOR FAMILIES AND INDIVIDUALS

SCHEDULE OF BENEFITS

This Policy includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

The Policy refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. As Your needs change over the time You own this Policy, You may change some of these benefits without replacing or purchasing a new Policy. Some of the provisions of this Policy require automatic changes. For example, when a Dependent no longer qualifies for coverage under this Policy due to their age, that Dependent's coverage will terminate.

Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	Refer to Your ID Card
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

NON-PEDIATRIC (ADULT) SCHEDULE FOR COVERED PERSONS AGE 19 AND OVER

Cash Deductible Information

Deductible per Insured per Benefit Year
(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Cash Deductible:
Group I Services $60.00

Non-Preferred Provider Benefit Year Cash Deductible:
Group I Services $120.00

Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

Preferred Provider Payment Rate for:
Group I Services 100%
Group II Services 0%
Group III Services 0%
Group IV (Orthodontic) Services 0%

Non-Preferred Provider Payment Rate for:

Group I Services 100%
Group II Services 0%
Group III Services 0%
Group IV (Orthodontic) Services 0%

Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximum

Annual Maximum per Covered Person $1,000.00

Preferred Provider and Non-Preferred Provider Waiting Periods

Group I Services ..... None

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons who are eligible for the Pediatric Dental Services explained below until the end of the month in which they turn 19 years of age.

Pediatric Dental Services Cash Deductible Information

Deductible per Insured Child per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services $60.00
Group IV Services ..... None

Non-Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services $120.00
Group IV Services ..... None

Pediatric Dental Services Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

Preferred Provider Payment Rates:

Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 50%

Non-Preferred Provider Payment Rates:

Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 0%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximums:

Group I, Group II, Group III and Group IV Services ..... None

Preferred Provider and Non-Preferred Provider Orthodontics Lifetime Maximum ..... None

Preferred Provider Out of Pocket Annual Maximum Per Insured Child $450.00
Preferred Provider Out of Pocket Annual Maximum For Two or More Insured Children $900.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. The maximum out of pocket limit will not exceed $450.00 for each Covered Person under age 19. If two or more Covered Persons under age 19 meet the maximum out of pocket limit of $900.00 in a Benefit Year, covered charges for services performed by a Preferred Provider will be reimbursed at 100% for all Covered Persons under age 19 for the rest of the Benefit Year.

Non-Preferred Provider Out of Pocket Annual Maximum ..... None

Preferred Provider and Non-Preferred Provider Waiting Periods:
Group I, Group II, Group III and Group IV Services ..... None

How It Works

This Policy is designed to provide high quality dental care while controlling the cost of such care. To do this, this Policy encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), which is called DentalGuard Preferred.

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) information about current Preferred Providers.

This Policy usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Policy. Please read this Policy carefully.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

Covered charges are the charges listed in the applicable fee schedule the Preferred Provider Dentist has agreed to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

A dental service received through the use of audio-visual communication, sometimes called teledentistry, will be considered for benefits just like an in-person service. Teledentistry is provided to you at a different physical location than the dentist, or health professional acting under the delegation and supervision of a dentist, using telecommunications or information technology.

How to Reach Us

Claim Dept.	Customer Care Team	On the Web
P O Box 981587 El Paso, TX 79998-1587	(844) 561-5600	dentalexchange.guardiandirect.com

NON-PEDIATRIC DENTAL SERVICES

List Of Covered Non-Pediatric Dental Services

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be usual and necessary treatment for a dental condition.

Group I Services (Diagnostic & Preventive)

Prophylaxis (Cleaning) and Fluorides

Prophylaxis - Cleaning : Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group III Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Office Visits, Evaluations and Examination

Comprehensive oral evaluation – limited to once every 36 consecutive months. Office visits, oral evaluations, limited oral evaluations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

After-hours office visit or emergency palliative treatment: Limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person’s employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker’s Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.

- Any service furnished solely for cosmetic reasons.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Any procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Bite registration or bite analysis.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplants.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations billed under CDT Code D0160.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant.
- Treatment of congenital or developmental malformations.
- Evaluations or treatment for Restorative, Endodontic, Periodontic, Prosthodontic or Oral Surgery care is not a covered benefit under this Plan.

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

The following information applies to Covered Persons who are eligible for the Pediatric Dental Services explained below until the end of the month in which they turn 19 years of age.

List Of Covered Pediatric Dental Services

The list below provides the Pediatric Dental Services required by your State.

Group I Services (Diagnostic & Preventive)

Prophylaxis (Cleaning) and Fluorides

Prophylaxis – Cleaning: Limited to a total of one prophylaxis in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to one treatment in any six consecutive month period.

Office Visits, Evaluations and Examination

Comprehensive oral evaluation, office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period. An oral evaluation can be provided with the eruption of the child's first tooth.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of two in any 12 consecutive month period.

After-hours office visit or emergency palliative treatment.

Space Maintainers

Space Maintainers: Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per 24 consecutive month period.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.
- Removable - bilateral.

Recementation of space maintainer.

Removal of fixed space maintainer.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Single radiographic image is included without limitation.

Either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, limited to once in any 12 consecutive month period.

Intraoral periapical, occlusal images or extraoral images.

Cephalometric radiographic image.

Dental Sealants

Dental Sealants or Preventive Resin Restoration: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth. Limited to one treatment, per tooth, per lifetime.

Group II Services (Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown for permanent and primary teeth.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Protective restoration.

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment.

Diagnostic casts.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

Other drugs or medicaments.

Application of desensitizing medicaments.

Group III Services (Major)

Group III Restorative Services

Crowns, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Limited to once, per tooth, in any 60 consecutive month period. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Coverage of temporary crowns is limited to fractured teeth and not a temporary crown that is placed on the tooth and worn while the permanent crown is being fabricated. Also see Exclusions sections for replacement information and limitations.

Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.
- Porcelain/ceramic crowns.

Porcelain/Ceramic Onlays.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only and to once, per tooth, in any 60 consecutive month period. Also, see Exclusions section for replacement information and limitations.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Retainer – case metal for resin bonded fixed prosthesis
- Retainer – porcelain/ceramic for resin bonded fixed prosthesis
- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance. Limited to once, per denture, in any 60 consecutive month period.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.

- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Crown and Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation:

- Onlay.
- Crown.
- Bridge.
- Post and Core.

Adding teeth and clasp to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation and nitrous oxide

Behavior management.

Treatment of complications (post surgical).

Feeding aid.

Hospital or ambulatory surgical center call.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment

Root canal retreatment Limited to once per tooth, per lifetime.

Treatment of root canal obstruction, no surgical access.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, per tooth, per lifetime.

Retrograde filling: Limited to once per root, per tooth, per lifetime.

Pulpal regeneration.

Periodontal Services

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis (cleaning) in any twelve month period. Allowance includes periodontal charting, scaling and polishing.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once per 12 consecutive month period.

Provisional splinting – intracoronal, extracoronal.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

Gingivectomy or gingivoplasty, per tooth or per quadrant: Once in any 24 consecutive month period.

Crown lengthening, hard tissue: Once per tooth, per lifetime.

Osseous surgery: Once in any 60 consecutive month period per quadrant.

Pedicle or free soft tissue grafts, including donor site.

Subepithelial connective tissue graft procedure.

Bone replacement grafts.

Periodontal Surgery Related

Occlusal guards for the grinding and clenching of teeth.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care.

Alveoloplasty, per quadrant.
Incision and drainage of abscess.
Frenulectomy, frenectomy, frenotomy.
Frenuloplasty.
Excision of hyperplastic tissue.
Excision of pericoronal gingiva, per tooth.
Oroantral fistula closure.
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
Primary closure of a sinus perforation.
Surgical access of an unerupted tooth.
Mobilization of erupted or malpositioned tooth to aid eruption.
Placement of device to facilitate eruption of impacted tooth.
Incisional biopsy.
Brush biopsy.
Removal of growth, cyst or tumor.
Removal of bone tissue.
Occlusal orthotic device for temporomandibular joint disorders (TMJ).
Surgical reduction of fibrous tuberosity.

Group IV Services (Orthodontics/Orthodontia)

Orthodontic/Orthodontia Services

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed to due to medical necessity.

- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits. Minor treatment to control harmful habits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.
- Replacement of lost or broken retainer.
- Fixed and removable Appliances for thumb sucking and tongue thrusting.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

Treatment Plan

A treatment plan should always be sent to us before Orthodontic Treatment starts.

How We Pay Benefits for Orthodontic Services

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent month upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan.

Exclusions

The Exclusions listed here apply to Covered Persons under the age of 19.

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.

- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition. This exclusion does not apply to feeding aids.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. This exclusion does not apply to feeding aids.
- Any procedure, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition except coverage of occlusal orthotic device.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to alter vertical dimension.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis except coverage for orthodontic retainers.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Implants and implant services.