**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

## 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.

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|---|---|
| **POLICYOWNER** | Refer to Your ID Card |
| **POLICY NUMBER** | Refer to Your ID Card |
| **EFFECTIVE DATE** | The Effective Date Approved by Us |
| **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 and Group II Services ……..$50.00

**Non-Preferred Provider Benefit Year Cash Deductible:**
Group I and Group II Services ……..$50.00

### 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..... 60%
Group III Services..... 0%
Group IV (Orthodontic) Services ..... 0%

**Non-Preferred Provider Payment Rate for:**
Group I Services..... 100%
Group II Services..... 60%
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 ..... $1,500.00

**Preferred Provider and Non-Preferred Provider Waiting Periods**
Group I Services ..... None
Group II Services ..... 6 Months

## PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained below.

## Pediatric Dental Services Cash Deductible Information

Deductible per Insured Child per Benefit Year

**Preferred Provider Benefit Year Cash Deductible:**
Group II and Group III Services ..... $200.00
Group I and Group IV (Orthodontic) Services ..... None

**Non-Preferred Provider Benefit Year Cash Deductible:**
Group II and Group III Services ..... $200.00
Group I and Group IV (Orthodontic) 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 ..... 80%
Group III Services ..... 50%
Group IV (Orthodontic) Services ..... 50%

**Non-Preferred Provider Payment Rates:**
Group I Services ..... 100%
Group II Services ..... 80%
Group III Services ..... 50%
Group IV (Orthodontic) Services ..... 50%

## Pediatric Dental Services Maximums and Waiting Periods

**Preferred Provider and Non-Preferred Provider Annual Maximums:**
Group I, Group II, Group III and Group IV (Orthodontics) ..... None
**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. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**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 (Orthodontics) 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<br>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 and Fluorides**

Prophylaxis : 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 II 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.

### 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 36 months have passed since the previous restoration was placed if the Covered Person is age 19 or older.

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

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. 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: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

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

**Diagnostic Services**

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

**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: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- 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.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, per lifetime.

Root amputation: Limited to once per root, per lifetime.

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

Hemisection, including any root removal: Once per tooth.

**Periodontal Services**

Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis in any six month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

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 in any 36 consecutive month period. Considered only when no diagnostic preventive , periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

**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.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

**Periodontal Surgery Related**

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

**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. **Services listed in this category and related services may be covered by Your medical plan**.
- 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. Services listed in this category and related services may be covered by Your medical plan.

- Alveoloplasty, per quadrant.
- Removal of exostosis, per site.
- Incision and drainage of abscess.
- Frenulectomy, frenectomy, frenotomy.
- Biopsy and examination of tooth related oral tissue.
- Brush biopsy
- Surgical exposure of impacted or unerupted tooth to aid eruption.
- Excision of tooth related tumors, cysts and neoplasms.
- Excision or destruction of tooth related lesion(s).
- Excision of hyperplastic tissue.
- Excision of pericoronal gingiva, per tooth.
- Oroantral fistula closure.
- Sialolithotomy.
- Sialodochoplasty.
- Closure of salivary fistula. Excision of salivary gland.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.
- Vestibuloplasty.

**Other Services**

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, and services listed under Other Surgical Procedures.

Injectable antibiotics needed solely for treatment of a dental condition.

## Waiting Periods For Certain Services

The following services when furnished by a Preferred Provider or Non-Preferred Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

## Limitations

**Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Plan:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

## 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, unless this Plan provides benefits for a specific cosmetic services. 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.
- Any procedure, Appliance, 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.
- 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: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment, unless the benefit provision provides specific benefits for 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.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

## PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

### List Of Covered Pediatric Dental Services

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

### Group I Services (Diagnostic & Preventive)

**Prophylaxis and Fluorides**

Prophylaxis: 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 two treatments in any twelve consecutive month period.

**Office Visits, Evaluations and Examination**

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six 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. Fixed - unilateral.

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

Recementation of space maintainer.

**Radiographs**

Allowance includes evaluation and diagnosis.

Full mouth series, of at least 14 images including bitewings, limited to one in any 60 consecutive month period.

Panoramic image, maxilla and mandible, with or without bitewing radiographs, limited to one in any 60 consecutive month period.

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 6 consecutive month period.

Intraoral periapical or occlusal images- single images.

**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, in any 36 consecutive month period.

## Group II Services (Basic)

**Restorative Services**

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

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. 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: Limited to once per tooth in any 60 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

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

**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.

## Group III Services (Major)

**Group III Restorative Services**

Crowns, inlays, 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.

Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement 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.

Inlays.

Onlays, including inlay.

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.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site.
- Radiographs/surgical implant index: Limited to once per arch in any 60 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

**Prosthodontic Services**

Specialized techniques and characterizations are not covered. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

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

Bridge abutments:

- 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.

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.

Simple stress breakers, per unit.

**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.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth 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 rebase, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase 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 reline, full or partial denture: Limited to once per denture in any 36 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.

Tissue conditioning.

**Other Services**

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under Other Surgical Procedures.

Detailed and extensive oral evaluations – problem focused, by report

**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.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification.

Apicoectomy.

Root amputation.

Retrograde filling.

Hemisection, including any root removal.

**Periodontal Services**

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis in any twelve month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

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 lifetime.

**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 (less than three teeth), once in any 36 consecutive month period.
- Crown lengthening, hard tissue.
- Gingivectomy or gingivoplasty, per quadrant, once in any 36 consecutive month period.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant, once in any 36 consecutive month period.
- Gingival flap procedure, including scaling and root planing, per quadrant, once in any 36 consecutive month period.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery, once in any 36 consecutive month period.
- Surgical revision procedure, per tooth, once in any 36 consecutive month period.
- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.
- Guided tissue regeneration, resorbable barrier or nonresorbable barrier, once in any 36 consecutive month period, limited to when the tooth is present.
- Bone replacement grafts, once in any 36 consecutive month period, limited to when the tooth is present.

**Periodontal Surgery Related**

Occlusal guards: Limited to one in a 12 consecutive month period.

**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. **Services listed in this category and related services may be covered by Your medical plan**.

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. **Services listed in this category and related services may be covered by Your medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Tooth reimplantation.

## Group IV Services (Orthodontics)

**Orthodontic Services**

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed due to severe, dysfunctional, or handicapping malocclusion.

- 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.

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) 30 months.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, 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 30 months 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 fix 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.

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.

### Limitations

**Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Plan:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after the Covered Dependent became covered by 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.
- 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 and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- .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: (1) alter vertical dimension or (2) splint or stabilize teeth for periodontal reasons.
- 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 Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- 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.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Orthodontic Treatment that is not medically necessary.
- 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.

### Discounts on Non-Orthodontic Dental Services Not Covered By This Plan

A Covered Person under this Policy can receive discounts on certain services not covered by this Policy, as described below, if:

(a) he or she receives services or supplies from a Dentist that is under contract with Guardian's dental preferred provider organizations (PPOs) network; and

(b) the service or supply is on the fee schedule the Dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this Policy. The Covered Person must pay the entire discounted fee directly to the Dentist. There is no need to file a claim.

When a person is no longer covered by this Policy, access to the network discount ends.

### Discounts on Services Not Covered Due To Contractual Provisions

If a Covered Person receives dental services from a Dentist who is under contract with Guardian's DentalGuard Preferred, such services will be provided at the discounted fee the Dentist agreed to accept as payment in full as a member of our DentalGuard Preferred network, even if such services are not covered by the Policy due to:

(a) meeting the plan's benefit year payment limit provision;

(b) frequency limitations; or

(c) policy exclusions, such as dental implants.

### Discounts on Orthodontic Services

If a Covered Person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

(a) pre-orthodontic treatment visit;

(b) limited orthodontic treatment;

(c) interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(d) comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(e) periodic comprehensive orthodontic treatment visit (as part of a contract); or

(f) orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- extractions performed solely to facilitate orthodontic treatment;
- orthognathic surgery and associated incremental charges; and
- replacement of lost or broken retainers.

***Diagnostic Services***

D0120 Periodic oral evaluation

D0140 Limited oral evaluation - problem focused

D0150 Comprehensive oral evaluation

D0160 Detailed and extensive oral evaluation

D0180 Comprehensive periodontal evaluation

D0210 Intraoral – comprehensive series of radiographic images

D0220 Intraoral - periapical radiographic image

D0230 Intraoral - additional periapical image

D0240 Intraoral - occlusal radiographic image

D0270 Bitewing - single image

D0272 Bitewings - two images

D0274 Bitewings - four images

D0277 Vertical bitewings – 7 to 8 images

D0330 Panoramic radiographic image

D0340 2D Cephalometric radiographic image-acquisition, measurement, and analysis

D0350 2D Oral/facial photographic image obtained intra-orally or extra-orally

D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

D0470 Diagnostic Models

***Preventive Services***

D1110 Prophylaxis – Adult

D1120 Prophylaxis – Child

D1206 Topical Fluoride - Varnish

D1208 Topical application of fluoride

D1351 Sealant - per tooth

D1352 Preventative resin restorations in a moderate to high caries risk patient

D1510 Space maintainer – fixed – unilateral

D1516 Space maintainer-fixed-bilateral, maxillary

D1517 Space maintainer-fixed-bilateral, mandibular

D1520 Space maintainer - removable – unilateral

D1526 Space maintainer-removable-bilateral, maxillary

D1527 Space maintainer-removable-bilateral, mandibular

D1551 re-cement or re-bond bilateral space maintainer-maxillary

D1552 re-cement or re-bond bilateral space maintainer-mandibular

D1553 re-cement or re-bond unilateral space maintainer-per quadrant

***Restorative Services***

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin–based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)

D2510 Inlay - metallic – one surface

D2520 Inlay - metallic – two surfaces

D2530 Inlay - metallic – three surfaces

D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

D2610 inlay – porcelain/ceramic – one surface

D2620 inlay – porcelain/ceramic – two surfaces

D2630 inlay – porcelain/ceramic – three or more surfaces

D2642 onlay – porcelain/ceramic – two surfaces

D2643 onlay – porcelain/ceramic – three surfaces

D2644 onlay – porcelain/ceramic – four or more surface

D2740 Crown - porcelain/ceramic substrate

D2750 Crown - porcelain fused to high noble metal

D2751 Crown - porcelain fused to predominately base metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - 3/4 cast high noble metal

D2781 Crown - 3/4 cast predominately base metal

D2783 Crown - 3/4 porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominately base metal

D2792 Crown - full cast noble metal

D2794 Crown – titanium

D2910 Re-cement inlay

D2920 Re-cement crown

D2929 Prefabricated porcelain crown - primary

D2930 Prefabricated stainless steel crown - primary tooth

D2931 Prefabricated stainless steel crown - permanent tooth

D2940 Protective Restoration

D2950 Core buildup, including any pins

D2951 Pin retention - per tooth, in addition to restoration

D2954 Prefabricated post and core, in addition to crown

D2980 Crown repair, by report

D2981 Inlay Repair

D2982 Onlay Repair

D2983 Veneer Repair

D2990 Resin infiltration/smooth surface

***Endodontic Services***

D3110 Pulp cap – direct (excluding final restoration)

D3120 Pulp cap – indirect (excluding final restoration)

D3220 Therapeutic pulpotomy (excluding final restoration)

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration)

D3310 Anterior root canal (excluding final restoration)

D3320 Bicuspid root canal (excluding final restoration)

D3330 Molar root canal (excluding final restoration)

D3331 Treatment of root canal obstruction; non-surgical access

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3333 Internal root repair of perforation defects

D3346 Retreatment of previous root canal therapy-anterior

D3347 Retreatment of previous root canal therapy-bicuspid

D3348 Retreatment of previous root canal therapy-molar

D3351 Apexification/recalcification – initial visit

D3352 Apexification/recalcification – interim medication replacement

D3353 Apexification/recalcification - final visit

D3355 Pulpal regeneration-initial visit

D3356 Pulpal regeneration-interim medication replacement

D3357 Pulpal regeneration-completion of treatment

D3410 Apicoectomy/periradicular surgery - anterior

D3421 Apicoectomy/periradicular surgery - bicuspid (first root)

D3425 Apicoectomy/periradicular surgery - molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3430 Retrograde filling – per root

D3450 Root amputation - per root

D3920 Hemisection (including any root removal) - not including root canal therapy

***Periodontic Services***

D4210 Gingivectomy or gingivoplasty – four or more teeth

D4211 Gingivectomy or gingivoplasty – one to three teeth

D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth

D4240 Gingival flap procedure, four or more teeth

D4241 Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant

D4249 Clinical crown lengthening-hard tissue

D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant

D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant

D4263 Bone replacement graft – retained natural tooth – first site in quadrant

D4264 Bone replacement graft – retained natural tooth – each additional site in quadrant

D4266 Guided tissue regeneration, natural teeth – resorbable barrier, per site

D4267 Guided tissue regeneration, natural teeth – non-resorbable barrier, per site

D4268 Surgical revision procedure

D4270 Pedicle soft tissue graft procedure

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft

D4274 Mesial/distal wedge procedure, single tooth

D4275 Non-Autogenous connective tissue graft

D4277 Free soft tissue graft - first tooth

D4278 Free soft tissue graft - additional teeth

D4341 Periodontal scaling and root planning-four or more teeth per quadrant

D4342 Periodontal scaling and root planning-one to three teeth, per quadrant

D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit

D4910 Periodontal maintenance

D4921 Gingival irrigation with a medicinal agent - per quadrant

***Prosthodontic Services, removable***

D5110 Complete denture - maxillary

D5120 Complete denture - mandibular

D5130 Immediate denture - maxillary

D5140 Immediate denture - mandibular

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)

D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)

D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5282 Removable unilateral partial denture–one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary

D5283 Removable unilateral partial denture–one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular

D5284 Removable unilateral partial denture–one piece flexible base(including retentive/clasping materials, rests, and teeth)–per quadrant

D5286 Removable unilateral partial denture–one piece resin (including retentive/clasping materials, rests, and teeth)–per quadrant.

D5410 Adjust complete denture – maxillary

D5411 Adjust complete denture – mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture – mandibular

D5511 Repair broken complete denture base, mandibular

D5512 Repair broken complete denture base, maxillary

D5520 Replace missing or broken teeth - complete denture (each tooth)

D5611 Repair resin partial denture base mandibular

D5612 repair resin partial denture base, maxillary

D5621 Repair cast partial framework, mandibular

D5622 Repair cast partial framework, maxillary

D5630 Repair or replace broken clasp

D5640 Replace broken teeth - per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5710 Rebase complete maxillary denture

D5720 Rebase maxillary partial denture

D5721 Rebase mandibular partial denture

D5730 Reline complete maxillary denture

D5731 Reline complete mandibular denture

D5740 Reline maxillary partial denture

D5741 Reline mandibular partial denture

D5750 Reline complete maxillary denture (laboratory)

D5751 Reline complete mandibular denture (laboratory)

D5760 Reline maxillary partial denture (laboratory)

D5761 Reline mandibular partial denture (laboratory)

D5850 Tissue conditioning (maxillary)

D5851 Tissue conditioning (mandibular)

***Implant Services***

D6010 Endosteal Implant

D6012 Surgical Placement of Interim Implant Body

D6040 Eposteal Implant

D6050 Transosteal Implant

D6055 Connecting Bar – implant or abutment supported

D6056 Prefabricated Abutment

D6057 Custom Abutment

D6058 Abutment supported porcelain ceramic crown

D6059 Abutment supported porcelain fused to high noble metal

D6060 Abutment supported porcelain fused to predominately base metal crown

D6061 Abutment supported porcelain fused to noble metal crown

D6062 Abutment supported cast high noble metal crown

D6063 Abutment supported cast predominately base metal crown

D6064 Abutment supported cast noble metal crown

D6065 Implant supported porcelain/ceramic crown

D6066 Implant supported porcelain fused to high metal crown

D6067 Implant supported metal crown

D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture

D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture

D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture

D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture

D6072 Abutment supported retainer for cast high noble metal fixed partial denture

D6073 Abutment supported retainer for predominately base metal fixed partial denture

D6074 Abutment supported retainer for cast noble metal fixed partial denture

D6075 Implant supported retainer for ceramic fixed partial denture

D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture

D6077 Implant supported retainer for cast metal fixed partial denture

D6080 Implant Maintenance Procedures

D6090 Repair Implant Prosthesis

D6091 Replacement of Semi-Precision or Precision Attachment

D6100 Implant Removal

D6101 Debridement per implant defect

D6102 Debridement and osseous per implant defect

D6103 Bone graft per implant defect

D6104 Bone graft implant replacement

D6105 – Removal of implant body not requiring bone removal nor flap elevation

D6106 - Guided tissue regeneration - resorbable barrier, per implant

D6107 – Guided tissue regeneration – non-resorbable barrier, per implant

D6110 – Implant/abutment supported removable denture for edentulous arch - maxillary

D6111 – Implant/abutment supported removable denture for edentulous arch - mandibular

D6112 - Implant/abutment supported removable denture for partially edentulous arch - maxillary

D6113 - Implant/abutment supported removable denture for partially edentulous arch - mandibular

D6114 – Implant/abutment supported fixed denture for edentulous arch - maxillary

D6115 - Implant/abutment supported fixed denture for edentulous arch - mandibular

D6116 - Implant/abutment supported fixed denture for partially edentulous arch - maxillary

D6117 - Implant/abutment supported fixed denture for partially edentulous arch - mandibular

D6118 – Implant/abatement supported interim fixed denture for edentulous arch - mandibular

D6119 - Implant/abatement supported interim fixed denture for edentulous arch - maxillary

D6190 Implant Index

D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant

***Prosthodontic Services, fixed***

D6210 Pontic - cast high noble metal

D6211 Pontic - cast predominately base metal

D6212 Pontic - cast noble metal

D6214 Pontic – titanium

D6240 Pontic - porcelain fused to high noble metal

D6241 Pontic - porcelain fused to predominately base metal

D6242 Pontic - porcelain fused to noble metal

D6245 Pontic - porcelain/ceramic

D6520 Inlay – metallic – two surfaces

D6530 Inlay – metallic – three or more surfaces

D6543 Onlay – metallic – three surfaces

D6544 Onlay – metallic – four or more surfaces

D6545 Retainer - cast metal for resin bonded fixed prosthesis

D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis

D6740 Crown - porcelain/ceramic

D6750 Crown - porcelain fused to high noble metal

D6751 Crown - porcelain fused to predominately base metal

D6752 Crown - porcelain fused to noble metal

D6780 Crown - 3/4 cast high noble metal

D6781 Crown - 3/4 cast predominately base metal

D6782 Crown - 3/4 cast noble metal

D6783 Crown - 3/4 porcelain/ceramic

D6790 Crown - full cast high noble metal

D6791 Crown - full cast predominately base metal

D6792 Crown - full cast noble metal

D6930 Recement fixed partial denture

D6980 Fixed partial denture repair, by report

***Oral Surgery***

D7111 Extraction, coronal remnants – primary tooth

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

D7220 Removal of impacted tooth - soft tissue

D7230 Removal of impacted tooth – partially bony

D7240 Removal of impacted tooth - completely bony

D7241 Removal of impacted tooth - completely bony with unusual surgical complications

D7250 Surgical removal of residual tooth roots (cutting procedure)

D7251 Coronectomy - intentional partial tooth removal

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7280 Exposure of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - per quadrant

D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

D7320 Alveoloplasty not in conjunction with extractions - per quadrant

D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

D7340 Vestibuloplasty

D7471 Removal of exostosis

D7509 Marsupialization of odontogenic cyst

D7510 Incision and drainage of abscess - intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7953 Bone replacement graft for ridge preservation-per site

D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site

D7957 Guided tissue regeneration, edentulous area - non-resorbable barrier, per site

D7961 Buccal/labial frenectomy (frenulectomy)

D7962 Lingual frenectomy (frenulectomy)

D7963 Frenuloplasty

D7970 Excision of hyperplastic tissue – per arch

D7971 Excision of pericoronal gingiva

D7921 Collection and application of autologous blood concentrate product

***Orthodontic Services***

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

***General Services***

D9110 Palliative treatment of dental pain -per visit

D9222 Deep sedation/general anesthesia – first 15-minutes

D9223 Deep sedation/general anesthesia – each subsequent 15-minute increment

D9239 Intravenous moderate (conscious) sedation/analgesia – first 15-minute increment

D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment

D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

D9610 Therapeutic drug injection, by report

D9930 Treatment of complications (post-surgical) unusual circumstances, by report

D9944 occlusal guard–hard appliance, full arch

D9945 occlusal guard–soft appliance, full arch

D9946 occlusal guard–hard appliance, partial arch