GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
INDIVIDUALS
GUARDIAN PREVENTIVE FOR FAMILIES AND INDIVIDUALS
SCHEDULE OF BENEFITS

Plan Overview		**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible			
Per covered person		$50	$75
Per Family (up to 3 family members)		$150 max	$225 max
PEDIATRIC BENEFITS - For covered dependents under age 26			
Out-of-Pocket Maximum - *Out-of-Pocket Maximums do not apply to adult benefits.*			
For one child		$450	None
Two or more children		$900	None
Diagnostic and Preventive Services	Limitations		
Oral Exams	Twice every 12 months	$0 coinsurance after deductible	$0 coinsurance after deductible
Periapical X-Ray			
Bitewing X-Ray Series	Once every 12 months		
Panoramic X-Ray or Complete Series	Once every 36 months		
Cleanings	Twice every 12 months		
Fluoride			
Sealants	Once per molar tooth every 36 months.		
Basic Services	Limitations		
Fillings		50% coinsurance after deductible	50% coinsurance after deductible
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		50% coinsurance after deductible	50% coinsurance after deductible
Endodontic Therapy (Root Canal Treatment)			
Periodontal Therapy			
Periodontal Scaling and Root Planing	Once per quadrant per 36 months		
Periodontal Maintenance	Twice every 12 months		
Crowns and Cast Restorations	Once per tooth every 60 months		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Once per appliance every 60 months		
Other Services	Limitations		
Medically Necessary Orthodontic Services		50% coinsurance after deductible	Not Covered. 100% member cost share
ADULT BENEFITS – For covered persons aged 26 or above			
Plan Maximum – *Plan Maximums do not apply to pediatric benefits.*			
Plan Maximum per covered person – Combined for In-Network and Out-of-Network Services)		$1,000	
Diagnostic and Preventive Services	Limitations		
Oral Exams	Once every 6 months	$0 coinsurance after deductible	$0 coinsurance after deductible
Periapical X-Ray			
Bitewing X-Ray Series	Once every 12 months		
Panoramic X-Ray or Complete Series	Once every 60 months		
Cleanings	Once every 6 months		
Fluoride	Not Covered		
Sealants	Not Covered		

Plan Overview		In-Network Member Pays	Out-of-Network Member Pays
ADULT BENEFITS (continued) – For adults aged 26 or above			
Basic Services	Limitations		
Fillings		Not Covered. 100% member cost share.	Not Covered. 100% member cost share.
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		Not Covered. 100% member cost share.	Not Covered. 100% member cost share.
Endodontic Therapy (Root Canal Treatment)			
Periodontal Scaling and Root Planing			
Periodontal Maintenance			
Periodontal Therapy			
Crowns and Cast Restorations			
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)			
Other Services	Limitations		
Medically Necessary Orthodontic Services		Not Covered. 100% member cost share.	Not Covered. 100% member cost share.
Waiting Periods – *Waiting periods do not apply to pediatric benefits.*			
Diagnostic and Preventive Services		No waiting period	
^Waiver of waiting period available with proof of prior coverage for these services under a dental insurance plan when the termination date was no more than 30 days prior to the effective date of this plan.			

Important information

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.

GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
INDIVIDUALS
GUARDIAN PREVENTIVE FOR FAMILIES AND INDIVIDUALS
SCHEDULE OF BENEFITS

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

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 26

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 two prophylaxis in any 12 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.

Office Visits, Evaluations and Examination

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of two in any 12 consecutive month period.

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.

- 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 36 consecutive month period.

Panoramic image, maxilla and mandible, with or without bitewing radiographs, limited to one in any 36 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 12 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.

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.

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. See the Exclusions section for replacement 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 Policy. 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 two 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 36 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.

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.

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 to due to severe, dysfunctional, 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) 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 three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Policy.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this Policy. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this Policy to charges determined to be incurred by the Covered Person while covered by this Policy. Based on the original treatment plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Policy 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 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.

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 Policy.

Limitations

Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Policy:

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 Policy. 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 Policy.

Exclusions

The Exclusions listed here apply to Covered Persons under the age of 26.

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 Policy.
- 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.
- 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.
- 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 Policy.
- The use of local anesthetic.
- Orthodontic Treatment that is not medically necessary.
- 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.

NON-PEDIATRIC (ADULT) DENTAL SERVICES

List Of Covered Non-Pediatric (Adult) Dental Services

The services covered by this Policy 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

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 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

The Exclusions listed here apply to Covered Persons age 26 and older.

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 Policy.
- Any service furnished solely for cosmetic reasons, unless this Policy 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.
- Bite registration or bite analysis.
- The use of anesthetics.
- 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.
- Evaluations or treatment for Restorative, Endodontic, Periodontic, Prosthodontic or Oral Surgery care is not a covered benefit under this Policy.