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.

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

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.)

Benefit Year Deductible:
Group I, Group II and Group III Services.....$50.00

Payment Rates

Payment Rate for:
Group I Services..... 100%
Group II Services..... 50%
Group III Services..... 0%
Group IV (Orthodontic) Services 0%

Maximums and Waiting Periods

Annual Maximum
Annual Maximum per Covered Person $1,000.00

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.

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.

Pediatric Dental Services Deductible Information

Deductible per Insured Child per Benefit Year

Benefit Year Deductible:

Group I, Group II, and Group III Services.....$50.00
Group IV (Orthodontic) Services .....None

Pediatric Dental Services Payment Rates

Payment Rates:

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

Pediatric Dental Services Maximums and Waiting Periods

Annual Maximum:
Group I, Group II, Group III and Group IV (Orthodontics) .....None

Lifetime Maximum:
Group I, Group II, Group III and Group IV (Orthodontics) .....None

Out of Pocket Annual Maximum Per Insured Child..... $450.00
Out of Pocket Annual Maximum For Two or More Insured Children..... $900.00

(The **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 dental provider will be reimbursed at 100%.)

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. When You enroll in this Policy, You and Your covered dependents receive a dental insurance ID card.

A Covered Person must present his or her ID card when he or she uses a dental provider. Most dental providers prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy's benefit payments. Any benefit payable by Us is sent directly to you or the dental provider if you have authorized payment to be sent to your dental 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.

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

How to Reach Us

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

NON-PEDIATRIC DENTAL SERVICES

List Of Covered Non-Pediatric Dental Services

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

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.

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 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.

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.

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.

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.

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.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years 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 Plan.
- 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.
- Evaluations or treatment for Endodontics, Periodontics or Oral Surgery are not a covered benefit under this Plan.

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.

Diagnostic and Treatment Services

CDT CODE	Description of Service	Frequency of Coverage (if applicable)	Category of Services Covered
D0120	Periodic oral evaluation	Limited to 1 every 6 months	Covered as a Group I Service
D0140	Limited oral evaluation- problem focused	Limited to 1 every 6 months	Covered as a Group I Service
D0150	Comprehensive oral evaluation	Limited to 1 every 6 months	Covered as a Group I Service
D0160	Detailed and extensive oral evaluation	problem focused, by report	Covered as a Group III Service
D0180	Comprehensive periodontal evaluation	Limited to 1 every 6 months	Covered as a Group I Service
D0210	Intraoral – comprehensive series of radiographic images	1 every 60 (sixty) months	Covered as a Group I Service
D0220	Intraoral – periapical first film	periapical first film	Covered as a Group I Service
D0230	Intraoral – periapical	each additional film	Covered as a Group I Service
D0240	Intraoral – occlusal film	Not applicable	Covered as a Group I Service
D0270	Bitewing – single film Adult	1 set every calendar year / Children -1 set every 6 months –	Covered as a Group I Service
D0272	Bitewings – two films Adult	1 set every calendar year / Children -1 set every 6 months	Covered as a Group I Service

D0274	Bitewings – four films Adult	1 set every calendar year / Children -1 set every 6 months	Covered as a Group I Service
D0277	Vertical bitewings – 7 to 8 films – Adult	1 set every calendar year / Children -1 set every 6 months	Covered as a Group I Service
D0330	Panoramic film	1 film every 60 (sixty) months	Covered as a Group I Service
D0340	Cephalometric x-ray	Not applicable	Covered as a Group **I** Service
D0350	Oral / Facial Photographic Images	Not applicable	Covered as a Group **I** Service
D0391	Interpretation of Diagnostic Image	Not applicable	Covered as a Group I Service
D0422	Collect & Prep Genetic Sample	1 per lifetime	Covered as a Group II Service
D0423	Genetic Test-Specimen Analysis	1 per lifetime	Covered as a Group II Service
D0470	Diagnostic Models	Not applicable	Covered as a Group II Service

Preventive Services

CDT CODE	**Description of Service**	**Frequency of Coverage (if applicable)**	**Category of Services Covered**
D1110	Prophylaxis – Adult	Limited to 1 every 6 months	Covered as a Group I Service
D1120	Prophylaxis – Child	Limited to 1 every 6 months	Covered as a Group I Service
D1206	Topical fluoride varnish	Over age 22-1 in 12 months; Less than age 22-1 in 12 months	Covered as a Group I Service
D1208	Topical application of fluoride (excluding prophylaxis)	Less than age 22-2 ever 12 months	Covered as a Group I Service
D1351	Sealant - per tooth - unrestored permanent molars	Less than age 19-1 sealant per tooth every 36 months	Covered as a Group I Service
D1352	Preventative resin restorations in a moderate to high caries risk patient - permanent tooth	1 sealant per tooth every 36 months	Covered as a Group I Service
D1354	Interim Caries Medicament – Permanent teeth	1 per tooth every 36 months (Molars /Bicuspids excluding Wisdom Teeth)	Covered as a Group I Service
D1510	Space maintainer – fixed – unilateral per quadrant	Limited to children under age 19	Covered as a Group I Service

D1515	Space maintainer – fixed – unilateral	Limited to children under age 19	Covered as a Group I Service
D1520	Space maintainer - removable – unilateral	Limited to children under age 19	Covered as a Group I Service
D1525	Space maintainer - removable – bilateral	Limited to children under age 19	Covered as a Group I Service
D1550	Re-cementation or rebond space maintainer	Not applicable	Covered as a Group I Service

Restorative Services

CDT CODE	Description of Service	Frequency of Coverage (if applicable)	Category of Services Covered
D2140	Amalgam - one surface, primary or permanent	Not applicable	Covered as a Group II Service
D2150	Amalgam - two surfaces, primary or permanent	Not applicable	Covered as a Group II Service
D2160	Amalgam - three surfaces, primary or permanent	Not applicable	Covered as a Group II Service
D2161	Amalgam - four or more surfaces, primary or permanent	Not applicable	Covered as a Group II Service
D2330	Resin–based composite - one surface, anterior	Not applicable	Covered as a Group II Service
D2331	Resin-based composite - two surfaces, anterior	Not applicable	Covered as a Group II Service
D2332	Resin-based composite - three surfaces, anterior	Not applicable	Covered as a Group II Service
D2335	Resin-based composite - four or more surfaces (anterior)	Not applicable	Covered as a Group II Service
D2510	Inlay - metallic – one surface – An alternate benefit will be provided	Not applicable	Covered as a Group III Service
D2520	Inlay - metallic – two surfaces – An alternate benefit will be provided	Not applicable	Covered as a Group III Service
D2530	Inlay - metallic – three surfaces – An alternate benefit will be provided	Not applicable	Covered as a Group III Service
D2542	Onlay - metallic - two surfaces	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2543	Onlay - metallic - three surfaces	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2544	Onlay - metallic - four or more surfaces	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2740	Crown - porcelain/ceramic substrate	Limited to 1 per tooth every 60 months	Covered as a Group III Service

D2750	Crown - porcelain fused to high noble metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2751	Crown - porcelain fused to predominately base metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2752	Crown - porcelain fused to noble metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2780	Crown - 3/4 cast high noble metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2781	Crown - 3/4 cast predominately base metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2783	Crown - 3/4 porcelain/ceramic	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2790	Crown - full cast high noble metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2791	Crown - full cast predominately base metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2792	Crown - full cast noble metal	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2794	Crown – titanium	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2910	Re-cement inlay or re-bond inlay, onlay, veneer or partial coverage restoration	Not applicable	Covered as a Group III Service
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not applicable	Covered as a Group III Service
D2920	Re-cement or re-bond crown	Not applicable	Covered as a Group III Service
D2929	Prefabricated porcelain crown – primary	Limited to 1 per tooth every 60 months	Covered as a Group II Service
D2930	Prefabricated stainless steel crown - primary tooth – Under age 15	Limited to 1 per tooth every 60 months	Covered as a Group II Service
D2931	Prefabricated stainless steel crown - permanent tooth - Under age 15	Limited to 1 per tooth every 60 months	Covered as a Group II Service
D2940	Protective Restoration	Not applicable	Covered as a Group II Service
D2950	Core buildup, including any pins	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2951	Pin retention - per tooth, in addition to restoration	Not applicable	Covered as a Group II Service
D2954	Prefabricated post and core, in addition to crown	Limited to 1 per tooth every 60 months	Covered as a Group III Service
D2980	Crown repair, by report	Not applicable	Covered as a Group III Service

D2981	Inlay Repair	Not applicable	Covered as a Group III Service
D2982	Onlay Repair	Not applicable	Covered as a Group III Service
D2983	Veneer Repair	Not applicable	Covered as a Group III Service
D2990	Resin infiltration/smooth surface	Limited to 1 in 36 months	Covered as a Group II Service

Endodontic Services

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D3220	Therapeutic pulpotomy (excluding final restoration)	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	Covered as a Group III Service
D3222	Partial pulpotomy for apexogenesis	permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately	Covered as a Group III Service
D3230	Pulpal therapy (resorbable filling)	anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.	Covered as a Group III Service
D3240	Pulpal therapy (resorbable filling)	Posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you	Covered as a Group III Service

		discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.	
D3310	Anterior root canal (excluding final restoration)	Not applicable	Covered as a Group III Service
D3320	Bicuspid root canal (excluding final restoration)	Not applicable	Covered as a Group III Service
D3330	Molar root canal (excluding final restoration)	Not applicable	Covered as a Group III Service
D3346	Retreatment of previous root canal therapy-anterior	Not applicable	Covered as a Group III Service
D3347	Retreatment of previous root canal therapy-bicuspid	Not applicable	Covered as a Group III Service
D3348	Retreatment of previous root canal therapy-molar	Not applicable	Covered as a Group III Service
D3351	Apexification/recalcification	Initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Covered as a Group III Service
D3352	Apexification/recalcification– interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	Not applicable	Covered as a Group III Service
D3353	Apexification/recalcification	final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)	Covered as a Group III Service
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	Not applicable	Covered as a Group III Service
D3410	Apicoectomy/periradicular surgery - anterior	Not applicable	Covered as a Group III Service
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Not applicable	Covered as a Group III Service
D3425	Apicoectomy/periradicular surgery - molar (first root)	Not applicable	Covered as a Group III Service
D3426	Apicoectomy/periradicular surgery (each additional root)	Not applicable	Covered as a Group III Service

D3450	Root amputation - per root	Not applicable	Covered as a Group III Service
D3920	Hemisection (including any root removal) - not including root canal therapy	Not applicable	Covered as a Group III Service

Periodontal Services

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	Category of Services Covered
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4212	Gingivectomy or gingivoplasty – to allow access for restorative procedure, per tooth	Limited to 1 every 36 months	Covered as a Group III Service
D4240	Gingival flap procedure including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4249	Clinical crown lengthening-hard tissue	Not applicable	Covered as a Group III Service
D4260	Osseous surgery (including full thickness flap and closure), four or more contiguous teeth or bounded teeth spaces per quadrant)	Limited to 1 every 36 months	Covered as a Group III Service
D4261	Osseous surgery (including full thickness flap and closure), one to three contiguous teeth or bounded teeth spaces per quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4263	Bone replacement graft – retained natural tooth - first site in quadrant	Limited to 1 every 36 months	Covered as a Group III Service
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Limited to 1 every 36 months	Covered as a Group III Service
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	Limited to 1 every 36 months	Covered as a Group III Service
D4270	Pedicle soft tissue graft procedure	Not applicable	Covered as a Group III Service

D4273	Autogenous connective tissue graft procedures(including donor site surgery)	Not applicable	Covered as a Group III Service
D4275	Non-Autogenous connective tissue graft	Limited to 1 every 36 months	Covered as a Group III Service
D4277	Free soft tissue graft 1st tooth	Not applicable	Covered as a Group III Service
D4278	Free soft tissue graft additional teeth	Not applicable	Covered as a Group III Service
D4283	Subepithelial tissue graft/each additional continguous tooth, implant or edentulous tooth position in the same graft site	Not applicable	Covered as a Group III Service
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in the same graft site	Limited to 1 every 36 months	Covered as a Group III Service
D4341	Periodontal scaling and root planning-four or more teeth per quadrant	Limited to 1 every 24 months	Covered as a Group III Service
D4342	Periodontal scaling and root planning-one to three teeth, per quadrant	Limited to 1 every 24 months	Covered as a Group III Service
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Limited to 1 per lifetime	Covered as a Group III Service
D4910	Periodontal maintenance	4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy	Covered as a Group III Service

Prosthodontic Services

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D5110	Complete denture - maxillary	Limited to 1 every 60 months	Covered as a Group III Service
D5120	Complete denture - mandibular	Limited to 1 every 60 months	Covered as a Group III Service
D5130	Immediate denture - maxillary	Limited to 1 every 60 months	Covered as a Group III Service
D5140	Immediate denture - mandibular	Limited to 1 every 60 months	Covered as a Group III Service

D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5213	Maxillary partial denture - cast metal framework with resin denture base(including retentive/clasping materials, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5214	Mandibular partial denture - cast metal framework with resin denture base(including retentive/clasping materials, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5223	Immediate maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5224	Immediate mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth)	Limited to 1 every 60 months	Covered as a Group III Service
D5410	Adjust complete denture – maxillary	Not applicable	Covered as a Group III Service
D5411	Adjust complete denture – mandibular	Not applicable	Covered as a Group III Service
D5421	Adjust partial denture – maxillary	Not applicable	Covered as a Group III Service
D5422	Adjust partial denture – mandibular	Not applicable	Covered as a Group III Service
D5510	Repair broken complete denture base	Not applicable	Covered as a Group III Service
D5520	Replace missing or broken teeth - complete denture (each tooth)	Not applicable	Covered as a Group III Service
D5610	Repair resin denture base	Not applicable	Covered as a Group III Service

D5620	Repair cast framework	Not applicable	Covered as a Group III Service
D5630	Repair or replace broken clasp	Not applicable	Covered as a Group III Service
D5640	Replace broken teeth - per tooth	Not applicable	Covered as a Group III Service
D5650	Add tooth to existing partial denture	Not applicable	Covered as a Group III Service
D5660	Add clasp to existing partial denture	Not applicable	Covered as a Group III Service
D5710	Rebase complete maxillary denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5720	Rebase maxillary partial denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5721	Rebase mandibular partial denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5730	Reline complete maxillary denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5731	Reline complete mandibular denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5740	Reline maxillary partial denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5741	Reline mandibular partial denture	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5750	Reline complete maxillary denture (laboratory)	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5751	Reline complete mandibular denture (laboratory)	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service

D5760	Reline maxillary partial denture (laboratory)	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5761	Reline mandibular partial denture (laboratory) Rebase/Reline	Limited to 1 in a 36-month period 6 months after the initial installation	Covered as a Group III Service
D5850	Tissue conditioning (maxillary)	Not applicable	Covered as a Group III Service
D5851	Tissue conditioning (mandibular)	Not applicable	Covered as a Group III Service

Implant Services

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D6010	Endosteal Implant	1 every 60 months	Covered as a Group III Service
D6012	Surgical Placement of Interim Implant Body	1 every 60 months	Covered as a Group III Service
D6040	Eposteal Implant	1 every 60 months	Covered as a Group III Service
D6050	Transosteal Implant, Including Hardware	1 every 60 months	Covered as a Group III Service
D6055	Connecting Bar – implant or abutment supported	1 every 60 months	Covered as a Group III Service
D6056	Prefabricated Abutment	1 every 60 months	Covered as a Group III Service
D6057	Custom Abutment	1 every 60 months	Covered as a Group III Service
D6058	Abutment supported porcelain ceramic crown	1 every 60 months	Covered as a Group III Service
D6059	Abutment supported porcelain fused to high noble metal	1 every 60 months	Covered as a Group III Service
D6060	Abutment supported porcelain fused to predominately base metal crown	1 every 60 months	Covered as a Group III Service
D6061	Abutment supported porcelain fused to noble metal crown	1 every 60 months	Covered as a Group III Service
D6062	Abutment supported cast high noble metal crown	1 every 60 months	Covered as a Group III Service
D6063	Abutment supported cast predominately base metal crown	1 every 60 months	Covered as a Group III Service

D6064	Abutment supported cast noble metal crown	1 every 60 months	Covered as a Group III Service
D6065	Implant supported porcelain/ceramic crown	1 every 60 months	Covered as a Group III Service
D6066	Implant supported porcelain fused to high metal crown	1 every 60 months	Covered as a Group III Service
D6067	Implant supported metal crow	1 every 60 months	Covered as a Group III Service
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	1 every 60 months	Covered as a Group III Service
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6070	Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6072	Abutment supported retainer for cast high noble metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6073	Abutment supported retainer for predominately base metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6074	Abutment supported retainer for cast noble metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6075	Implant supported retainer for ceramic fixed partial denture	1 every 60 months	Covered as a Group III Service
D6076	Implant supported retainer for porcelain fused to high noble metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6077	Implant supported retainer for cast metal fixed partial denture	1 every 60 months	Covered as a Group III Service
D6078	Implant/abutment supported fixed partial denture for complete	1 every 60 months	Covered as a Group III Service
D6080	Implant Maintenance Procedures	1 every 60 months	Covered as a Group III Service
D6089	Accessing and retorquing loose implant screw – per screw	Not applicable	Covered as a Group III Service
D6090	Repair Implant Prosthesis	1 every 60 months	Covered as a Group III Service
D6091	Replacement of Semi-Precision or Precision Attachment	1 every 60 months	Covered as a Group III Service

D6100	Implant Removal	1 every 60 months	Covered as a Group III Service
D6101	Debridement peri-implant defect, covered if implants are covered	Limited to 1 every 60 months	Covered as a Group III Service
D6102	Debridement and osseous peri-implant defect, covered if implants are covered	Limited to 1 every 60 months	Covered as a Group III Service
D6103	Bone graft peri-implant defect, covered if implants are covered	Not applicable	Covered as a Group III Service
D6104	Bone graft implant replacement, covered if implants are covered	Not applicable	Covered as a Group III Service
D6105	Removal of implant body not requiring bone removal nor flap elevation	Not applicable	Covered as a Group III Service
D6106	Guided tissue regeneration - resorbable barrier, per implant	Not applicable	Covered as a Group III Service
D6107	Guided tissue regeneration - non-resorbable barrier, per implant	Not applicable	Covered as a Group III Service
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	1 every 60 months	Covered as a Group III Service
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	1 every 60 months	Covered as a Group III Service
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	1 every 60 months	Covered as a Group III Service
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	1 every 60 months	Covered as a Group III Service
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	1 every 60 months	Covered as a Group III Service
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	1 every 60 months	Covered as a Group III Service
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	1 every 60 months	Covered as a Group III Service
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	1 every 60 months	Covered as a Group III Service
D6190	Implant Index	1 every 60 months	Covered as a Group III Service

D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	Not applicable	Covered as a Group III Service

Prosthodontic Services, fixed

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D6210	Pontic - cast high noble metal	Limited to 1 every 60 months	Covered as a Group III Service
D6211	Pontic - cast predominately base metal	Limited to 1 every 60 months	Covered as a Group III Service
D6212	Pontic - cast noble metal	Limited to 1 every 60 months	Covered as a Group III Service
D6214	Pontic – titanium	Limited to 1 every 60 months	Covered as a Group III Service
D6240	Pontic - porcelain fused to high noble meta	Limited to 1 every 60 months	Covered as a Group III Service
D6241	Pontic - porcelain fused to predominately base metal	Limited to 1 every 60 months	Covered as a Group III Service
D6242	Pontic - porcelain fused to noble metal	Limited to 1 every 60 months	Covered as a Group III Service
D6245	Pontic - porcelain/ceramic	Limited to 1 every 60 months	Covered as a Group III Service
D6519	Inlay/onlay – porcelain/ceramic	Limited to 1 every 60 months	Covered as a Group III Service
D6520	Inlay – metallic – two surfaces	Limited to 1 every 60 months	Covered as a Group III Service
D6530	Inlay – metallic – three or more surfaces	Limited to 1 every 60 months	Covered as a Group III Service
D6543	Onlay – metallic – three surfaces	1 every 60 months	Covered as a Group III Service
D6544	Onlay – metallic – four or more surfaces	1 every 60 months	Covered as a Group III Service
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 every 60 months	Covered as a Group III Service
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	1 every 60 months	Covered as a Group III Service
D6549	Resin retainer for resin bonded fixed prosthesis	1 every 60 months	Covered as a Group III Service
D6740	Crown - porcelain/ceramic	1 every 60 months	Covered as a Group III Service

D6750	Crown - porcelain fused to high noble metal	1 every 60 months	Covered as a Group III Service
D6751	Crown - porcelain fused to predominately base metal	1 every 60 months	Covered as a Group III Service
D6752	Crown - porcelain fused to noble metal	1 every 60 months	Covered as a Group III Service
D6780	Crown - 3/4 cast high noble metal	1 every 60 months	Covered as a Group III Service
D6781	Crown - 3/4 cast predominately base metal	1 every 60 months	Covered as a Group III Service
D6782	Crown - 3/4 cast noble metal	1 every 60 months	Covered as a Group III Service
D6783	Crown - 3/4 porcelain/ceramic	1 every 60 months	Covered as a Group III Service
D6790	Crown - full cast high noble metal	1 every 60 months	Covered as a Group III Service
D6791	Crown - full cast predominately base metal	1 every 60 months	Covered as a Group III Service
D6792	Crown - full cast noble metal	1 every 60 months	Covered as a Group III Service
D6930	Recement fixed partial denture	1 every 60 months	Covered as a Group III Service
D6980	Fixed partial denture repair, by report	1 every 60 months	Covered as a Group III Service

Oral Surgery

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Not applicable	Covered as a Group III Service
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Not applicable	Covered as a Group III Service
D7220	Removal of impacted tooth - soft tissue	Not applicable	Covered as a Group III Service
D7230	Removal of impacted tooth – partially bony	Not applicable	Covered as a Group III Service
D7240	Removal of impacted tooth - completely bony	Not applicable	Covered as a Group III Service

D7241	Removal of impacted tooth - completely bony with unusual surgical complications	Not applicable	Covered as a Group III Service
D7250	Surgical removal of residual tooth roots (cutting procedure)	Not applicable	Covered as a Group III Service
D7251	Coronectomy - intentional partial tooth removal	Not applicable	Covered as a Group III Service
D7252	Partial extraction for immediate implant placement	Not applicable	Covered as a Group III Service
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Not applicable	Covered as a Group III Service
D7280	Surgical access of an unerupted tooth	Not applicable	Covered as a Group III Service
D7284	Excisional biopsy of minor salivary glands	Not applicable	Covered as a Group III Service
D7310	Alveoloplasty in conjunction with extractions - per quadrant	Not applicable	Covered as a Group III Service
D7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	Not applicable	Covered as a Group III Service
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	Not applicable	Covered as a Group III Service
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	Not applicable	Covered as a Group III Service
D7471	Removal of exostosis	Not applicable	Covered as a Group III Service
D7509	Marsupialization of odontogenic cyst	Not applicable	Covered as a Group III Service
D7510	Incision and drainage of abscess - intraoral soft tissue	Not applicable	Covered as a Group III Service
D7910	Suture of recent small wounds up to 5 cm	Not applicable	Covered as a Group III Service
D7921	Collect – Apply Autologous Product	Not applicable	Covered as a Group III Service
D7953	Bone replacement graft for ridge preservation – per site	Not applicable	Covered as a Group III Service
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	Not applicable	Covered as a Group III Service
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	Not applicable	Covered as a Group III Service

D7971	Excision of pericoronal gingival	Not applicable	Covered as a Group III Service

General Services

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D9110	Palliative treatment of dental pain – per visit	minor procedure	Covered as a Group I Service
D9220	Deep sedation/general anesthesia	first 30 minutes	Covered as a Group III Service
D9221	Deep sedation/general anesthesia	each additional 15 minutes	Covered as a Group III Service
D9223	Deep sedation/general anesthesia	each additional 15 minutes	Covered as a Group III Service
D9241	Intravenous conscious sedation/analgesia	first 30 minutes	Covered as a Group III Service
D9242	Intravenous conscious sedation/analgesia	each additional 15 minutes	Covered as a Group III Service
D9243	Intravenous moderate (conscious) sedation/analgesia	each additional 15 minutes	Covered as a Group III Service
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment	Not applicable	Covered as a Group III Service
D9610	Therapeutic drug injection, by report	Not applicable	Covered as a Group II Service
D9930	Treatment of complications (post-surgical) unusual circumstances, by repor	Not applicable	Covered as a Group III Service
D9932	Cleaning and inspection of removable complete denture, maxillary	1 every 60 months	Covered as a Group III Service
D9933	Cleaning and inspection of removable complete denture, mandibula	1 every 60 months	Covered as a Group III Service
D9934	Cleaning and inspection of removable partial denture, maxillary	1 every 60 months	Covered as a Group III Service
D9935	Cleaning and inspection of removable partial denture, mandibular	1 every 60 months	Covered as a Group III Service
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	Covered when replacing an anterior tooth	Covered as a Group III Service
D9940	Occlusal guard, by report	1 in 12 months for patients 13 and older	Covered as a Group III Service
D9943	Occlusal guard adjustment	1 every 24 months	Covered as a Group III Service

Orthodontic Services

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed 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.

CDT CODE	**Description of Service**	**Frequency of Coverage** (if applicable)	**Category of Services Covered**
D8010	Limited orthodontic treatment of the primary dentition	Not applicable	Covered as a Group IV Service
D8020	Limited orthodontic treatment of the transitional dentition	Not applicable	Covered as a Group IV Service
D8030	Limited orthodontic treatment of the adolescent dentition	Not applicable	Covered as a Group IV Service
D8040	Limited orthodontic treatment of the adult dentition	Not applicable	Covered as a Group IV Service
D8050	Interceptive orthodontic treatment of the primary dentition	Not applicable	Covered as a Group IV Service
D8060	Interceptive orthodontic treatment of the transitional dentition	Not applicable	Covered as a Group IV Service
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not applicable	Covered as a Group IV Service
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Not applicable	Covered as a Group IV Service
D8090	Comprehensive orthodontic treatment of the adult dentition	Not applicable	Covered as a Group IV Service
D8091	Comprehensive orthodontic treatment with orthognathic surgery	Not applicable	Covered as a Group IV Service
D8210	Removable appliance therapy	Not applicable	Covered as a Group IV Service
D8220	Fixed appliance therapy	Not applicable	Covered as a Group IV Service
D8660	Pre-orthodontic treatment visit	Not applicable	Covered as a Group IV Service

D8670	Periodic orthodontic treatment visit (as part of contract	Not applicable	Covered as a Group IV Service
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	Not applicable	Covered as a Group IV Service
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)	Not applicable	Covered as a Group IV Service

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 Plan.

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

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.
- 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 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.