

Utah Essential Health Benefit – Guardian Essentials for Families and Individuals Plan

The Guardian Life Insurance Company of America

domiciled in the State of New York

This summary of benefits, along with the exclusions and limitations describe the benefits of the Essential Health Benefit – Guardian Essentials for Families and Individuals Plan. Please review closely to understand all benefits, exclusions and limitations.

Child-ONLY* Essential Health Benefit	In-Network	Out-of-Network**	Adult-ONLY* Guardian Essentials Plan	In-Network	Out-of-Network**
Class I/Preventive - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain and Radiographs (Bitewings, Full Mouth X-ray, Panoramic Film).	70%	70%	Class I/Preventive - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain, and Radiographs-Bitewings, Radiographs (Full Mouth X-ray, Panoramic Film)	100%	100%
Class II/Basic - Restorations (Amalgams and Anterior Resins), Simple Extractions and Anesthesia (General Anesthesia and Intravenous Sedation).	70%	70%	Class II/Basic - Restorations (Amalgams & Anterior Resin) and Simple Extractions.	50%	50%
Class III/Major - Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics, Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures and Denture Repair.	50%	50%	Class III/Major - Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures and Denture Repair, Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics and Anesthesia.	50%	50%
Class IV/Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	50% for medically necessary orthodontics		Class IV/Orthodontia	N/A	
Deductible (waived for Class I)(per person)	\$200		Deductible*** (not waived for Class I)(per person)	\$60	\$120
Out of Pocket Maximum (OOP) (per person)	\$350	N/A	Out of Pocket Maximum (OOP) (per person)	N/A	
Out of Pocket Maximum*** (OOP) (per family - 2+ children)	\$700	N/A	Out of Pocket Maximum (OOP) (per family - 2+ children)	N/A	
Annual Maximum	N/A		Annual Maximum	\$1,000	
Ortho Lifetime Maximum	N/A		Ortho Lifetime Maximum	N/A	
Waiting Period	None		Waiting Period (Waived with proof of prior coverage)****	6 months for Basic Services & 12 months for Major Services	

* This plan is available for individuals up to age 19.

**Out of Network benefits are based on the maximum amount which the In-Network Dentist has agreed with Guardian to accept as payment in full for the dental service.

***2 family members must each meet the out of pocket maximum in a plan year. Once fulfilled the family maximum has been met and will not be applied to additional family members.

* This plan is available for individuals ages 19 and over.

**Out of Network benefits are based on the maximum amount which the In-Network Dentist has agreed with Guardian to accept as payment in full for the dental service.

***When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that plan year.

****Prior group coverage not more than 30 days lapse prior to effective date.

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CLASSES OF COVERED SERVICES AND SUPPLIES (Individuals up to Age 19)

Coverage is provided for the dental services and supplies described in this section. Only those services as indicated below are required to be covered as a pediatric dental benefit in accordance with the requirements of this state. Only these services will be counted toward Your Out of Pocket Maximum.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

Class I: Preventive Dental Services

- Oral Exams (*pediatric dental benefit)
 - Limited to twice in a plan year for any combination of oral exams
- X-Rays (*pediatric dental benefit)
 - Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period, in lieu of panorex x-ray
 - Full series bitewing x-rays (4) are allowed only twice in a plan year;
 - A panorex is allowable once during any three-year period in lieu of complete mouth x-ray;
 - Vertical bitewings are payable up to eight films.
- Prophylaxis (Cleaning) (*pediatric dental benefit)
 - Limited to twice in a plan year
- Topical Fluoride Treatment (*pediatric dental benefit)
 - Limited to twice in a plan year

- Sealants (*pediatric dental benefit)
 - Sealant applications are limited to once per 60 month period, on un-restored pit and fissures of a 1st and 2nd permanent molar.
- Space Maintainer
 - Only for premature loss of deciduous (baby) posterior (back) teeth.
- Palliative Treatment
 - Treatment of Emergency Pain

Class II: Basic Dental Services

- Amalgam (silver) Restorations
 - Multiple restorations on 1 surface will be considered a single filling.
 - Multiple restorations on different surfaces of the same tooth will be considered connected.
 - Limited to once in 24 months
- Resin (tooth colored) Restorations – Anterior (front) teeth ONLY
 - Limited to once in 24 months for the same covered amalgam (resin) restoration
- Resin (tooth colored) Restorations – Posterior (back) teeth ONLY
 - Limited to the benefit of the corresponding amalgam restoration
 - Prior to placement member must be informed and agree to pay the cost difference
- Coronal remnants – deciduous tooth
- Extraction of erupted teeth or exposed root
- Consultation, including specialist consultations, limited as follows:

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- Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date.
- Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan
- General anesthesia and intravenous sedation, limited as follows:
 - Considered for payment as a separate benefit only when medically necessary (as determined by the Plan) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.
 - Not a benefit for the management of fear and anxiety
 - Oral sedation and nitrous oxide are covered for children through the age of 13

Class III: Major Dental Services

- Therapeutic pulpotomy (primary tooth) excluding final restoration
 - Benefit only for primary (baby) teeth
- Root canal therapy (anterior/bicuspid/molar) excluding final restoration
 - Benefit for permanent teeth only.
- Recement crown
- Prefabricated stainless steel crown (primary and permanent teeth); Prefabricated resin crown (anterior teeth only); Prefabricated stainless steel crown with resin window (anterior teeth only)
 - If more than one restoration is used to restore a tooth, benefit allowance will be paid for the most inclusive service;
 - Prefabricated crowns per tooth are benefits once in 24 month period
- Surgical removal of erupted teeth

- Removal of impacted teeth
 - Pathology removal of 3rd molar is not a covered benefit.

Class IV: Orthodontia

- Orthodontia is covered when medically necessary and pre-approved by the plan.

General Exclusions

(Individuals up to Age 19)

Covered Services and Supplies do not include:

- 1) Treatment which:
 - a) is not included in the list of Covered Services and Supplies;
 - b) is not Dentally Necessary; or
 - c) is Experimental in nature.
- 2) Any Charges which are:
 - a) Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
 - b) Not imposed against the person or for which the person is not liable.
 - c) Reimbursable by Medicare Part A and Part B. If a person at any time in the Medicare program (including Part B), his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by

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- law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
- 3) Services or supplies resulting from or in the course of Your or Your Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
 - 4) Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
 - a) a Close Relative or a person who ordinarily resides with You or a Dependent;
 - b) an Employee of the Employer;
 - c) the Employer.
 - 5) Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least three years, as determined by the Plan.
 - 6) Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
 - 7) Services and supplies provided primarily for cosmetic purposes.
 - 8) Covered services and supplies obtained while outside of the United States, except for Emergency Dental Care.
 - 9) Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
 - 10) Diagnostic casts, unless for medically necessary orthodontia.
 - 11) Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
 - 12) Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
 - 13) Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.
 - 14) Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
 - 15) Replacement of a lost or stolen Appliance or Prosthesis.
 - 16) Replacement of stayplates.
 - 17) Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
 - 18) Treatment for a jaw fracture.
 - 19) Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
 - 20) Therapeutic drug injection.
 - 21) Completion of claim forms.

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- 22) Missed dental appointments.
- 23) Porcelain and cast crowns
- 24) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam resin filling.
- 25) Pathology free third molar extraction or removal.
- 26) Crown build-up is not covered as a separate service.
- 27) Temporary tooth stabilization, other than covered space maintainers, is not covered.
- 28) Oral sedation and nitrous oxide analgesia are not covered, except for Children through age 13.
- 29) Implants, and procedures and appliances associated with them, are not benefits of Guardian programs.
- 30) Replacement of missing teeth prior to coverage effective date.

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CLASSES OF COVERED SERVICES AND SUPPLIES (Individuals age 19 and over)

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

Class I: Preventive Dental Services

- Comprehensive exams, periodic exams, evaluations, re-evaluations, limited oral exams, or periodontal evaluations. Limited to 1 per 6 month period
- Dental prophylaxis (cleaning and scaling). Benefit limited to either 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period, but not both.
- Palliative (emergency) treatment of dental pain
 - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the same visit.
- X-rays:
 - Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film. Limited to 1 per 60 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.

- Bitewing x-rays (two or four films). Limited to 1 per 12 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.
- Other X-rays:
 - Intraoral periapical x-rays.
 - Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.
 - Intraoral occlusal x-rays, limited to 1 film per arch per 6 month period.
 - Extraoral x-rays, limited to 1 film per 6 month period.
 - Other x-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).

Class II: Basic Dental Services

- Amalgam and composite restorations, limited as follows:
 - Multiple restorations on 1 surface will be considered a single filling.
 - Multiple restorations on different surfaces of the same tooth will be considered connected.
 - Benefits for replacement of an existing restoration will only be considered for payment if at least 36 months have passed since the existing restoration was placed.

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- Additional fillings on the same surface of a tooth in less than 36 months, by the same office or same Dentist are not covered.
- Sedative bases and liners are considered part of the restorative service and are not paid as separate procedures.
- Composite restorations are also limited as follows:
 - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations on anterior teeth will be considered single surface restorations
 - Acid etch is not covered as a separate procedure
 - Benefits limited to anterior teeth only.
 - Benefits for composite resin restorations on posterior teeth are limited to the benefit for the corresponding amalgam restoration.
- Pins, in conjunction with a final amalgam restoration
- Stainless steel crowns, limited to 1 per 36 month period for teeth not restorable by an amalgam or composite filling.
- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
 - Simple extractions
 - Root removal – exposed roots.
- Consultation, including specialist consultations, limited as follows:
 - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date.
 - Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.

Class III: Major Dental Services

- Inlays and onlays (metallic), limited as follows:
 - Covered only when the tooth cannot be restored by an amalgam or composite filling.
 - Covered only if more than 5 years have elapsed since last placement.
 - Build-up procedure is considered covered and is inclusive in the fee.
 - Benefits are based on the date of cementation.

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- Porcelain restorations on anterior teeth, limited as follows:
 - Covered only when the tooth cannot be restored by an amalgam or composite filling.
 - Covered only if more than 5 years have elapsed since last placement.
 - Limited to permanent teeth. Porcelain restorations on over-retained primary teeth are not covered.
 - Build-up procedure is considered covered and is inclusive in the fee.
 - Benefits are based on the date of cementation.
- Cast crowns, limited as follows:
 - Covered only when the tooth cannot be restored by an amalgam or composite filling.
 - Covered only if more than 5 years have elapsed since last placement.
 - Limited to permanent teeth. Cast crowns on over-retained primary teeth are not covered.
 - Crowns on third molars are covered when adjacent first or second molars are missing and the tooth is in function with an opposing natural tooth.
 - Build-up procedure is considered covered and inclusive in the fee.
 - Benefits are based on the date of cementation.
- Crown lengthening is limited to a single site when contiguous teeth are involved.
- Re-cementing inlays, crowns and bridges is limited to 3 per tooth, 12 months after last cementation.
- Post and core:
 - Covered only for endodontically- treated teeth, which require crowns.
- 1 post and core is covered per tooth.
- Full dentures, limited as follows:
 - Limited to 1 full denture per arch.
 - Replacement covered only if 5 years have elapsed since last replacement AND the full denture cannot be made serviceable (please refer to the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions).
 - Services include any adjustments or relines which are performed within 12 month of initial insertion.
 - We will not pay additional benefits for personalized dentures or over dentures or associated treatment.
 - Benefits for dentures are based on the date of delivery.
- Partial dentures, including any clasps and rests and all teeth, limited as follows:
 - Limited to 1 partial denture per arch.
 - Replacement covered only if 5 years have elapsed since last placement AND the partial denture cannot be made serviceable (please refer to the denture or bridge replacement/addition provision under exclusions and limitations for exceptions).
 - Services include any adjustments or relines which are performed within 12 months of initial insertion.
 - There are no benefits for precision or semi-precision attachments.
 - Benefits for partial dentures are based on the date of delivery.
- Denture adjustments are limited to:
 - 1 time in any 12 month period; and
 - Adjustments made more than 12 months after the insertion of the denture.

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- Repairs to full or partial dentures, bridges, and crowns are limited to repairs or adjustments performed up to 3 times after the initial insertion.
- Rebasing dentures are limited to 1 time per 12 month period.
- Relining dentures is a covered benefit 12 months after initial insertion of the denture.
 - Limited to 1 time per 12 month period
- Tissue conditioning is limited to 1 time in a 12 month period.
- Fixed bridges (including Maryland bridges) are limited as follows:
 - Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:
 - Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions); and
 - Cannot be made serviceable.
 - A fixed bridge replacing the extracted portion of a hemisected tooth is not covered.
 - Placement and replacement of a cantilever bridge on posterior teeth will not be covered.
 - Benefits for bridges are based on the date of cementation.
- Re-cementing bridges is limited to repairs or adjustment performed more than 12 months after the initial insertion.
- Pulpotomy (primary teeth only).
- Root canal therapy:
 - Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care.
 - Limited to 1 time on the same tooth per 24 month period by the same provider.
 - Limited to permanent teeth only.
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all preoperative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling - per root.
- Root amputation - per root.
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care does not include a benefit for root canal therapy.
- Periodontal scaling and root planing, limited as follows:
 - 4 or more teeth per quadrant, limited to a minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per quadrant per 24 month period.
 - 1 to 3 teeth per quadrant, limited to minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per area per 24 month period.
 - Under unusual circumstances, additional documentation can be submitted to the Plan for review.
 - Following osseous surgery root planing is a benefit after 36 months in the same area.
- Periodontal maintenance procedure (following active treatment). Benefit limited to either 1 periodontal maintenance procedure or 1 dental prophylaxis per 6 month period, but not both

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- Periodontal maintenance procedures may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than 3 months thereafter. The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.
- Periodontal related services as listed below, limited to 1 time per quadrant of the mouth in any 36 month period with charges combined for procedures as listed below:
 - Gingival flap procedures.
 - Gingivectomy procedures.
 - Osseous surgery.
 - Pedicle tissue grafts.
 - Soft tissue grafts.
 - Subepithelial tissue grafts.
 - Bone replacement grafts.
 - Guided tissue regeneration.
 - Crown lengthening procedures - hard tissue.
 - The most inclusive procedure will be considered for payment when 2 or more surgical procedures are performed.
- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
 - Surgical extractions, including extraction of third molars with pathology (wisdom teeth)
 - Alveoplasty
 - Vestibuloplasty
 - Removal of exostoses (including tori) – maxilla or mandible
 - Frenulectomy (frenectomy or frenotomy)
 - Excision of hyperplastic tissue – per arch
 - Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus, limited to permanent teeth only.
 - Biopsy
- Incision and drainage
- The most inclusive procedure will be considered for payment when 2 or more surgical procedures are performed.
- General anesthesia and intravenous sedation, limited as follows:
 - Considered for payment as a separate benefit only when medically necessary (as determined by the Plan) and when administered in the Dentist’s office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.
 - Not a benefit for the management of fear and anxiety;
 - Oral sedation is not a covered benefit.

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EXCLUSIONS AND LIMITATIONS (Individuals age 19 and over)

Treatment Outside of the United States

Treatment outside of the United States is not covered, unless the treatment is for emergency care. Coverage for emergency services is limited to a reimbursement amount of \$100.00. Please refer to your Policy for additional information regarding emergency care.

Missing Teeth Limitation

Initial placement of a full denture, partial denture or fixed bridge will not be covered by the Plan to replace teeth that were missing prior to the effective date of coverage for You or Your Dependents. However, expenses for the replacement of teeth that were missing prior to the effective date will only be considered for coverage, if the tooth was extracted within 12 months of the effective date of the Policy and while You or Your Dependent were covered under a Prior Plan.

Denture or Bridge Replacement/Addition

- Replacement of a full denture, partial denture, or fixed bridge is covered when:
 - 5 years have elapsed since last replacement of the denture or bridge; OR
 - The denture or bridge was damaged while in the Covered Person's mouth when an injury was suffered involving external, violent and accidental means. The injury must have occurred while insured under this Policy, and the appliance cannot be made serviceable.

However, the following exceptions will apply:

- Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth that cannot be added to the existing partial denture.

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- Benefits for the replacement of an existing fixed bridge that is less than 5 years old will be payable if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth, and the extracted tooth was not an abutment to an existing bridge.
 - Replacement of a lost bridge is not a Covered Benefit.
 - A bridge to replace extracted roots when the majority of the natural crown is missing is not a Covered Benefit.
 - Replacement of an extracted tooth will not be considered a Covered Benefit if the tooth was an abutment of an existing Prosthesis that is less than 5 years old.
 - Replacement of an existing partial denture, full denture, crown or bridge with more costly units/different type of units is limited to the corresponding benefit for the existing unit being replaced.
- b. Not imposed against the person or for which the person is not liable.
 - c. Reimbursable by Medicare Part A and Part B. If a person at any time in the Medicare program (including Part B), his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
 4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
 - a. a Close Relative or a person who ordinarily resides with You or a Dependent;
 - b. an Employee of the Employer;
 - c. the Employer.
 5. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least 3 years, as determined by the Plan.
 6. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.

Implants

Implants, and procedures and appliances associated with them, are not covered.

General Exclusions

Covered Services and Supplies do not include:

1. Treatment which is:
 - a. not included in the list of Covered Services and Supplies;
 - b. not Dentally Necessary; or
 - c. Experimental in nature.
2. Any Charges which are:
 - a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Plan will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.

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7. Services and supplies provided primarily for cosmetic purposes.
8. Services and supplies obtained while outside of the United States, except for Emergency Dental Care.
9. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
10. Diagnostic casts.
11. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
12. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
13. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
14. Veneers
15. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
16. Replacement of a lost or stolen Appliance or Prosthesis.
17. Replacement of stayplates.
18. Extraction of pathology-free teeth, including supernumerary teeth. (unless for medically necessary orthodontia)
19. Socket preservation bone graphs
20. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
21. Treatment for a jaw fracture.
22. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
23. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
24. Oral sedation and nitrous oxide analgesia are not covered.
25. Therapeutic drug injection.
26. Completion of claim forms.
27. Missed dental appointments.
28. Replacement of missing teeth prior to coverage effective date.