Arizona Essential Health Benefit – Guardian Essentials for Families and Individuals

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

Child-ONLY* Essential Health Benefit	In-Network	Out-of-Network**
Class I/Preventive - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain, and Radiographs-Bitewings	100%	100%
Class II/Basic - Radiographs (Full Mouth X-ray, Panoramic Film) Restorations (Amalgams and Anterior Resins), Simple Extractions and Anesthesia (General Anesthesia and Intravenous Sedation)	80%	80%
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 IV/Orthodontia *(Only for pre-authorized Medically Necessary Orthodontia)*	50% for medically necessary orthodontics	
Deductible (waived for Class I) (per person)	$250	
Out of Pocket Maximum (OOP) (per person)	$350	N/A
Out of Pocket Maximum*** (OOP) (per family - 2+ children)	$700	N/A
Annual Maximum	N/A	
Ortho Lifetime Maximum	N/A	
Waiting Period	None	

**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.*

Adult-ONLY* Guardian Essentials Plan	In-Network	Out-of-Network**
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 &Anterior Resin), and Simple Extractions.	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	N/A	
Deductible (waived for Class I) (per person)***	$75	
Out of Pocket Maximum (OOP) (per person)	N/A	
Out of Pocket Maximum (OOP) (per family - 2+ children)	N/A	
Annual Maximum	$1,000	
Ortho Lifetime Maximum	N/A	
Waiting Period (Waived with proof of prior coverage)****	6 months for Basic Services and 12 months for Major Services	

**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 coverage with a group plan not more than 30 days lapse prior to effective date.*

Benefits and Limitations (Individuals up to Age 19)

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.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - Limited to 1 every 6 months

D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months

D0150 Comprehensive oral evaluation - Limited to 1 every 6 months

D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months

D0210 Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months

D0220 Intraoral - periapical radiographic image D0230 Intraoral - additional periapical image D0240 Intraoral - occlusal radiographic image

D0270 Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months

D0272 Bitewings - two images - Adult - 1 set every calendar year/Children - 1 set every 6 months

D0274 Bitewings - four images - Adult - 1 set every calendar year/Children - 1 set every 6 months

D0277 Vertical bitewings – 7 to 8 images – Adult - 1 set every calendar year/Children - 1 set every 6 months

D0330 Panoramic radiographic image – 1 image every 60 (sixty) months

D0340 Cephalometric radiographic image

D0350 Oral / Facial Photographic Images D0391 Interpretation of Diagnostic Image D0470 Diagnostic Models

Preventative Services

D1110 Prophylaxis – Adult - Limited to 1 every 6 months

D1120 Prophylaxis – Child - Limited to 1 every 6 months

D1206 Topical Fluoride - Varnish - Over age 22 - 1 in 12 months, Less than age 22 - 2 every 12 months

D1208 Topical application of fluoride (excluding prophylaxis) - Less than age 22 - 2 every 12 months

D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months

D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.

D1510 Space maintainer – fixed – unilateral - Limited to children under age 19

D1515 Space maintainer – fixed – bilateral - Limited to children under age 19

D1520 Space maintainer - removable – unilateral - Limited to children under age 19

D1525 Space maintainer - removable – bilateral - Limited to children under age 19

D1550 Re-cementation of space maintainer - Limited to children under age 19

D9110 Palliative treatment of dental pain – minor procedure

Minor Restorative Services

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin–based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

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

D2910 Re-cement inlay

D2920 Re-cement crown

D2929 Prefabricated porcelain crown - primary - Limited to 1 every 60 months

D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months D2940 Protective Restoration

D2951 Pin retention - per tooth, in addition to restoration

Endodontic Services

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.

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.

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.

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you 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.

Periodontal Services

D4241 Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months

D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months

D4275 Non-Autogenous connective tissue graft – Limited to 1 every 36 months

D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months

D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months

D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy

D7921 Collect - Apply Autologous Product - Limited to 1 in 36 months

Prosthodontic Services

D5410 Adjust complete denture – maxillary

D5411 Adjust complete denture – mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture - mandibular

D5510 Repair broken complete denture base

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

D5610 Repair resin denture base

D5620 Repair cast framework

D5630 Repair or replace broken clasp

D5640 Replace broken teeth - per tooth D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5740 Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation

D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.

D5850 Tissue conditioning (maxillary) D5851 Tissue conditioning (mandibular)

D6057 Custom Abutment – 1 every 60 months

D6930 Recement fixed partial denture

D6980 Fixed partial denture repair, by report

Oral Surgery

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

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

D7220 Removal of impacted tooth - soft tissue

D7230 Removal of impacted tooth – partially bony

D7240 Removal of impacted tooth - completely bony

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

D7250 Surgical removal of residual tooth roots (cutting procedure)

D7251 Coronectomy - intentional partial tooth removal

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

D7280 Surgical access of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - per quadrant

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

D7320 Alveoloplasty not in conjunction with extractions - per quadrant

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

D7471 Removal of exostosis

D7510 Incision and drainage of abscess - intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7953 Bone replacement graft for ridge preservation-per site

D7971 Excision of pericoronal gingiva

Major Restorative Services

Note: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/ or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc was not placed while covered under PGuardian, or paid by Guardian, the frequency limitations may apply).

D0160 Detailed and extensive oral evaluation - problem focused, by report

D2510 Inlay - metallic – one surface – An alternate benefit will be provided

D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided

D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided

D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months

D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months

D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months

D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months

D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months

D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months

D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months

D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months

D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months

D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months

D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months

D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months

D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months

D2794 Crown – titanium– Limited to 1 per tooth every 60 months

D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months

D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months

D2980 Crown repair, by report

D2981 Inlay Repair D2982 Onlay Repair

D2983 Veneer Repair

D2990 Resin infiltration/smooth surface - Limited to 1 in 36 months

Endodontic Services

D3310 Anterior root canal (excluding final restoration)

D3320 Bicuspid root canal (excluding final restoration)

D3330 Molar root canal (excluding final restoration)

D3346 Retreatment of previous root canal therapy-anterior

D3347 Retreatment of previous root canal therapy-bicuspid

D3348 Retreatment of previous root canal therapy-molar

D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp does not include final restoration

D3410 Apicoectomy/periradicular surgery - anterior

D3421 Apicoectomy/periradicular surgery - bicuspid (first root)

D3425 Apicoectomy/periradicular surgery - molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3450 Root amputation - per root

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

Periodontal Services

D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months

D4211 Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months

D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months

D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months

D4249 Clinical crown lengthening-hard tissue

D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months

D4270 Pedicle soft tissue graft procedure

D4273 Subepithelial connective tissue graft procedures (including donor site surgery)

D4277 Free soft tissue graft - 1st tooth

D4278 Free soft tissue graft - additional teeth

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime

Prosthodontic Services

D5110 Complete denture - maxillary – Limited to 1 every 60 months

D5120 Complete denture - mandibular – Limited to 1 every 60 months

D5130 Immediate denture - maxillary – Limited to 1 every 60 months

D5140 Immediate denture - mandibular – Limited to 1 every 60 months

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months

Note: An implant is a covered procedure of the plan only if determined to be a dental necessity. Guardian claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

D6010 Endosteal Implant - 1 every 60 months

D6012 Surgical Placement of Interim Implant Body - 1 every 60 months

D6040 Eposteal Implant – 1 every 60 months

D6050 Transosteal Implant, Including Hardware – 1 every 60 months

D6053 Implant supported complete denture

D6054 Implant supported partial denture

D6055 Connecting Bar – implant or abutment supported - 1 every 60 months

D6056 Prefabricated Abutment – 1 every 60 months

D6058 Abutment supported porcelain ceramic crown -1 every 60 months

D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months

D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months

D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months

D6062 Abutment supported cast high noble metal crown - 1 every 60 months

D6063 Abutment supported cast predominately base metal crown - 1 every 60 months

D6064 Abutment supported cast noble metal crown - 1 every 60 months

D6065 Implant supported porcelain/ceramic crown - 1 every 60 months

D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months

D6067 Implant supported metal crown - 1 every 60 months

D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months

D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months

D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months

D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months

D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months

D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months

D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months

D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months

D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months

D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months

D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months

D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months

D6080 Implant Maintenance Procedures -1 every 60 months

D6090 Repair Implant Prosthesis -1 every 60 months

D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months

D6095 Repair Implant Abutment - 1 every 60 months

D6100 Implant Removal - 1 every 60 months

D6101 Debridement per implant defect, covered if implants are covered - Limited to 1 every 60 months

D6102 Debridement and osseous per implant defect, covered if implants are covered - Limited to 1 every 60 months

D6103 Bone graft per implant defect, covered if implants are covered

D6104 Bone graft implant replacement, covered if implants are covered

D6190 Implant Index - 1 every 60 months

D6210 Pontic - cast high noble metal – Limited to 1 every 60 months

D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months

D6212 Pontic - cast noble metal– Limited to 1 every 60 months

D6214 Pontic – titanium – Limited to 1 every 60 months

D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months

D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months

D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months

D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months

D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months

D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months

D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months

D6543 Onlay – metallic – three surfaces - 1 every 60 months

D6544 Onlay – metallic – four or more surfaces -1 every 60 months

D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months

D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months

D6740 Crown - porcelain/ceramic - 1 every 60 months

D6750 Crown - porcelain fused to high noble metal - 1 every 60 months

D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months

D6752 Crown - porcelain fused to noble metal - 1 every 60 months

D6780 Crown - 3/4 cast high noble metal - 1 every 60 months

D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months

D6782 Crown - 3/4 cast noble metal - 1 every 60 months

D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months

D6790 Crown - full cast high noble metal - 1 every 60 months

D6791 Crown - full cast predominately base metal - 1 every 60 months

D6792 Crown - full cast noble metal - 1 every 60 months

D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

Orthodontic Services - limited to children up to age 19

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition - limited to children up to age 19

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

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

Anesthesia Services

D9223 Deep sedation/general anesthesia – each 15 minute increment

Intravenous Sedation

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

Consultations

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

Medications

D9610 Therapeutic drug injection, by report

Post Surgical Services

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

Exclusions

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.

We do not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 19 and over;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Guardian.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Guardian.
- All out of network services listed in this Schedule of Benefits are subject to the maximum allowable fee charges as defined by Guardian. The member is responsible for all remaining charges that exceed the allowable maximum.
- Any service not listed in the benefits section.
- Replacement of missing teeth prior to coverage effective date.

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.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

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.
- Topical fluoride treatment.
    - Limited to 1 per 6 month period.
- 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.
- Sealant applications are limited to 1 per 36 month period, on un-restored pit and fissures of a 1st and 2nd permanent molar.
- Space maintainers, including all adjustments made within 6 months of installation.
- 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 (except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy).
    - Additional fillings on the same surface of a tooth in less than 36 months, by the same office or same Dentist are not covered, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy.
    - 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.
- 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 overdentures 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.
- 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
- 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 hyperplasic tissue – per arch
- Tooth re-implantation and/or stabilization of accidentally avulsed 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.

EXCLUSIONS AND LIMITATIONS

Treatment Outside of the Covered Service Area

Treatment outside of your covered state and/or 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 Certificate of Insurance 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.
- 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.

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.
   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 was entitled to enroll in the Medicare program (including Part B) but did not do so, 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. All services for which a claim is received more than 6 months after the date of service.
7. 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.

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