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 Schedule of Benefits refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule of Benefits summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. All Covered Persons less than age 19 are eligible for pediatric dental services. When You or Your Dependent Spouse or Domestic Partner no longer qualify for pediatric dental services due to age, You will then be eligible for non-pediatric dental services. When a Dependent child no longer qualifies for coverage under this Policy due to their age, that Dependent child'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 DENTAL SCHEDULE FOR COVERED PERSONS AGE 19 AND OLDER

Cash Deductible Information

Deductible per Covered Person per Benefit Year
(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services $60.00

Non-Pediatric Dental Services Covered Percentages

Preferred Provider Covered Percentage for services provided by a DentalGuard Preferred Provider.

Preferred Provider Covered Percentages for:

Group I Services 100%
Group II Services 50%
Group III Services 40%
Group IV (Orthodontic) Services..... 0%

Maximums and Waiting Periods

Preferred Provider Annual Maximum

Annual Maximum per Covered Person..... $1,000.00

Preferred Provider Waiting Periods

Group I Services.....None
Group II Services.....6 Months
Group III Services.....12 Months

Procedures and services performed by a non-preferred provider are not covered.

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

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

Pediatric Dental Services Cash Deductible Information

Deductible per Covered Person per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services $60.00
Group IV (Orthodontic) Services..... None

Pediatric Dental Services Covered Percentages

Covered Percentage for services provided by a DentalGuard Preferred Provider.

Preferred Provider Covered Percentages:

Group I Services 100%
Group II Services 50%
Group III Services 40%
Group IV (Orthodontic) Services 50%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontic) Services .....None

Preferred Provider Orthodontics Lifetime Maximum.....None

Preferred Provider Out of Pocket Annual Maximum Per Covered Person..... $375.00
Preferred Provider Out of Pocket Annual Maximum For Two or More Covered Persons..... $750.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

Preferred Provider Waiting Periods:
Group I, Group II, Group III, and Group IV (Orthodontic) Services .....None

Procedures and services performed by a non-preferred provider are not covered.

How It Works

DentalGuard Preferred is made up of preferred providers in a Covered Person's geographic area. To receive benefits from this Policy, the Covered Person must receive services from a Preferred Provider. This Policy pays no benefits for the services provided by a non-preferred provider. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) information about current Preferred Providers.

A Covered Person must present his or her ID card when he or she use a Preferred Provider. The Preferred Provider will prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Policy. Please read this Policy carefully.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

The Maximum Allowed Charges is the maximum amount which the Preferred Provider has agreed with Guardian to accept as payment in full for the dental services included in the List of Covered Dental Services below.

How to Reach Us

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

NON-PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS AGE 19 AND OLDER

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 Dentally Necessary.

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

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment 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 twelve 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 at least 36 months have passed since the previous restoration was placed.

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.

Group III Services (Major)

Group III Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

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

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

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

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.

- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

Crown And Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

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

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment

Root canal retreatment: Limited to once per tooth, per lifetime.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, per lifetime.

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

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

Hemisection, including any root removal: Once per tooth.

Periodontal Services

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

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 36 consecutive month period. Considered only when no diagnostic preventive, periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

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

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

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

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

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

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

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

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

Periodontal Surgery Related

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

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

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Sialolithotomy.

Sialodochoplasty.

Closure of salivary fistula. Excision of salivary gland.

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Vestibuloplasty.

Other Services

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

Injectable antibiotics needed solely for treatment of a dental condition.

Waiting Periods For Certain Services

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

Group II Services

Group III Services

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

Limitations

Teeth Lost, **Extracted or Missing Before A Covered Person Become Covered By This Policy:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Policy. We won't pay for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after the Covered Dependent became covered by this Policy.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) a facility owned or run by any governmental body; and (2) 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.
- 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.
- Procedures and services performed by a non-preferred provider.

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

List Of Covered Pediatric Dental Services

The list below provides the Pediatric Dental Services based upon the NJ CHIP plan and selected as NJ's benchmark plan.

Group I Services (Diagnostic & Preventive)

Prophylaxis And Fluorides

- Dental prophylaxis once every 6 months*
- Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*. Fluoride varnish once every 3 months for children under the age of 6.

* Preventive services that can be considered every 3 months for individuals with special healthcare needs.

Office Visits, Evaluations And Examination

Clinical oral evaluations once every 6 months *

- Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation

- Periodic oral evaluation – subsequent thorough evaluation of an established patient*
- Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
- Limited oral evaluations that are problem focused
- Detailed oral evaluations that are problem focused

* Preventive services that can be considered every 3 months for individuals with special healthcare needs.

Space Maintainers

Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal.

- fixed – unilateral and bilateral
- removable – bilateral only
- recementation of fixed space maintainer
- removal of fixed space maintainer – considered for provider that did not place appliance

Diagnostic Imaging with Interpretation

- A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
- An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
- Additional films/views needed for diagnosing can be provided as needed.
- Bitewings, periapicals, panoramic and cephlometric radiographic images
- Intraoral and extraoral radiographic images
- Oral/facial photographic images
- Maxillofacial MRI, ultrasound
- Cone beam image capture
- Tests and Examinations
- Viral culture
- Collection and preparation of saliva sample for laboratory diagnostic testing
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- Oral pathology laboratory
- Accession/collection of tissue, examination – gross and microscopic, preparation and
- transmission of written report
- Accession/collection of exfoliative cytologic smears, microscopic examination,
- preparation and transmission of a written report
- Other oral pathology procedures, by report

Dental Sealants

Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of a sealant will be considered with prior authorization.

Group II Services (Basic)

Restorative Services

There are no frequency limits on replacing restorations (fillings). Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause. Reimbursement will include the

restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia. The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service. Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.

- Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, polishing and adjusting occlusion.
- Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
- Pin retention.
- Protective restoration/sedative filling.

Group III Services (Major)

Group III Restorative Services

There are no frequency limits on replacing restorations or crowns. Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause. Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.

- Gold foil - Service includes local anesthesia, polishing and adjusting occlusion.
- Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion.
- Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion. Provisional crowns are not covered.
- Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown.
- Core buildup including pins.
- Indirectly fabricated (custom fabricated/cast) and prefabricated post and core.
- Additional fabricated (custom fabricated/cast) and prefabricated post.
- Post removal.
- Temporary crown (fractured tooth).
- Additional procedures to construct new crown under existing partial denture.
- Coping.
- Crown repair.

Prosthodontic Services

All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.

- Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis.
- Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
- Provisional crowns are not covered.

New dentures or replacement dentures may be considered every 7 years unless dentures become obsolete due to additional extractions or are damaged beyond repair. All needed dental treatment must be completed prior to denture fabrication. Insertion of dentures includes adjustments for 6 months post insertion. Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

- Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
- Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
- Resin base and cast frame dentures including any conventional clasps, rests and teeth
- Flexible base denture including any clasps, rests and teeth
- Removable unilateral partial dentures or dentures without clasps are not considered
- Overdenture – complete and partial
- Denture adjustments –6 months after insertion or repair
- Denture repairs – includes adjustments for first 6 months following service
- Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
- Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
- Precision attachment, by report

Maxillofacial prosthetics - includes adjustments for first 6 months following service:

- Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
- Obturator prosthesis: surgical, definitive and modifications
- Mandibular resection prosthesis with and without guide flange
- Feeding aid
- Surgical stents
- Radiation carrier
- Fluoride gel carrier
- Commissure splint
- Surgical splint
- Topical medicament carrier
- Adjustments, modification and repair to a maxillofacial prosthesis
- Maintenance and cleaning of maxillofacial prosthesis

Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.

- Covered services include: implant body, abutment and crown.

Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.

- Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
- Abutment teeth must be periodontally sound and have a good long term prognosis
- Repair and recementation
- Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Endodontic Services

Service requires prior authorization Service includes all necessary radiographs or views needed for endodontic treatment. Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis. Emergency services for pain do not require prior authorization.

- Therapeutic pulpotomy for primary and permanent teeth
- Pulpal debridement for primary and permanent teeth
- Partial pulpotomy for apexogensis
- Pulpal therapy for anterior and posterior primary teeth
- Endodontic therapy and retreatment
- Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- Apexification: initial, interim and final visits
- Pulpal regeneration
- Apicoectomy/Periradicular Surgery
- Retrograde filling
- Root amputation
- Surgical procedure for isolation of tooth with rubber dam
- Hemisection
- Canal preparation and fitting of preformed dowel or post
- Post removal

Periodontal Services

- Gingivectomy and gingivoplasty
- Gingival flap including root planning
- Apically positioned flap
- Clinical crown lengthening
- Osseous surgery
- Bone replacement graft – first site and additional sites
- Biologic materials to aid soft and osseous tissue regeneration
- Guided tissue regeneration
- Surgical revision
- Pedicle and free soft tissue graft
- Subepithelial connective tissue graft
- Distal or proximal wedge

- Soft tissue allograft
- Combined connective tissue and double pedicle graft

Non-Surgical Periodontal Service

- Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
- Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
- Full mouth debridement to enable comprehensive evaluation
- Localized delivery of antimicrobial agents
- Periodontal maintenance

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

- Extraction of coronal remnants – deciduous tooth
- Extraction, erupted tooth or exposed root
- Surgical removal of erupted tooth or residual root
- Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
- Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved
- Oroantral fistula
- Primary closure of sinus perforation and sinus repairs
- Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
- Surgical access of an unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to aid eruption
- Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
- Surgical repositioning of tooth/teeth
- Transseptal fiberotomy/supra crestal fiberotomy
- Surgical placement of anchorage device with or without flap
- Harvesting bone for use in graft(s)
- Alveoloplasty in conjunction or not in conjunction with extractions
- Vestibuloplasty
- Excision of benign and malignant tumors/lesions
- Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
- Destruction of lesions by electrosurgery
- Removal of lateral exostosis, torus palatinus or torus madibularis
- Surgical reduction of osseous tuberosity
- Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider

- Surgical Incision
- Incision and drainage of abcess - intraoral and extraoral
- Removal of foreign body
- Partial ostectomy/sequestrectomy
- Maxillary sinusotomy
- Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
- Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
- Manipulation under anesthesia
- Condylectomy, discectomy, synovectomy
- Joint reconstruction
- Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
- Arthroscopy
- Occlusal orthotic device – includes placement and removal to same provider
- Surgical and other repairs
- Repair of traumatic wounds – small and complicated
- Skin and bone graft and synthetic graft
- Collection and application of autologous blood concentrate
- Osteoplasty and osteotomy
- LeFort I, II, III with or without bone graft
- Graft of the mandible or maxilla – autogenous or nonautogenous
- Sinus augmentations
- Repair of maxillofacial soft and hard tissue defects
- Frenectomy and frenoplasty
- Excision of hyperplastic tissue and pericoronal gingiva
- Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
- Emergency tracheotomy
- Coronoidectomy
- Implant – mandibular augmentation purposes

Adjunctive General Services

- Palliative treatment for emergency treatment – per visit

Anesthesia

- Local anesthesia NOT in conjunction with operative or surgical procedures.
- Regional block

- Trigeminal division block.
- Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
- Intravenous conscious sedation/analgesia – 2 hour maximum time
- Nitrous oxide/analgesia
- Non-intravenous conscious sedation – to include oral medications
- Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.

Consultation by specialist or non-primary care provider

Professional visits

- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
- For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
- General anesthesia and outpatient facility charges for dental services are covered
- Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

Drugs

- Therapeutic parenteral drug, Single administration
- Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report
- Application of desensitizing medicament – per visit

Occlusal guard – for treatment of bruxism, clenching or grinding

Athletic mouthguard covered once per year

Occlusal adjustment

- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

Odontoplasty

Internal bleaching

Group IV Services (Orthodontics)

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.

- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

- Limited treatment for the primary, transitional and adult dentition
- Interceptive treatment for the primary and transitional dentition
- Minor treatment to control harmful habits
- Continuation of transfer cases or cases started outside of the program
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the
- HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
- Orthognathic Surgical Cases with comprehensive orthodontic treatment
- Repairs to orthodontic appliances
- Replacement of lost or broken retainer
- Rebonding or recementing of brackets and/or bands
- Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.
- Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

How We Pay Benefits for Orthodontic Services For Covered Persons Under Age 19

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.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this 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) a facility owned or run by any governmental body; and (2) 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.
- 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, charges for broken appointments. A Covered Person may seek the services of a new provider through which additional services are available.
- 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.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis. This exclusion does not apply to Orthodontic retainers.
- The replacement of extracted or missing third molars/wisdom teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Procedures and services performed by a non-preferred provider.