

Covered Dental Services And Patient Charges - Plan 30 M

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *primary care dentist* selected by the *member*.

The *member* must pay the listed *patient charge*. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions.

These *patient charges* may not be valid in all states.

Codes+	Description of Service	Patient Charge
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Appointments and Diagnostic Services

0101	Office Visit - during regular hours - participating general dentist only . .	\$5.00
0102	Broken Appointment (without 24 hours' notice)	\$25.00
0120, 0140, 0150	Oral evaluation	No Charge
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge
9310	Consultation (by dentist other than practitioner providing treatment)	No Charge
9430	Office visit for observation - regular hours - no other service performed	No Charge
9440	Emergency office visit - after regularly scheduled office hours	\$50.00

Radiographs

0210	Intraoral - complete series (including bitewings)	No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film	No Charge
0270, 0272, 0274	Bitewings	No Charge
0330	Panoramic film	No Charge

Preventive Services & Space Maintenance

1110, 1120	Prophylaxis	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child . .	No Charge
1310	Nutritional counseling for control of dental diseases	No Charge

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1330	Oral hygiene instruction	No Charge
1351	Sealant - per tooth	\$10.00
1510	Space maintainer - fixed - unilateral	\$50.00
1515	Space maintainer - fixed - bilateral	\$90.00
1550	Recementation of space maintainer	\$10.00

Restorative

2110	Amalgam - one surface - primary	\$10.00
2120	Amalgam - two surfaces - primary	\$10.00
2130	Amalgam - three surfaces - primary	\$15.00
2131	Amalgam - four or more surfaces - primary	\$15.00
2140	Amalgam - one surface - permanent	\$10.00
2150	Amalgam - two surfaces - permanent	\$10.00
2160	Amalgam - three surfaces - permanent	\$15.00
2161	Amalgam - four or more surfaces - permanent	\$15.00
2210	Silicate cement - per restoration	\$15.00
2330	Resin/composite - one surface, anterior	\$20.00
2331	Resin/composite - two surfaces, anterior	\$30.00
2332	Resin/composite - three surfaces, anterior	\$35.00
2335	Resin/composite - four or more surfaces or incisal angle, anterior . . .	\$40.00
2336	Composite resin crown, anterior - primary	\$35.00
2380	Resin/composite - one surface, posterior - primary	\$25.00
2381	Resin/composite - two surfaces, posterior - primary	\$35.00
2382	Resin/composite - three or more surfaces, posterior - primary	\$40.00
2385	Resin/composite - one surface, posterior - permanent	\$30.00
2386	Resin/composite - two surfaces, posterior - permanent	\$40.00
2387	Resin/composite - three or more surfaces, posterior - permanent . . .	\$50.00

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Crown, Bridge & Other Cast Restorations

2510	Inlay - metallic - one surface*	\$155.00
2520, 6520	Inlay - metallic - two surfaces*	\$190.00
2530, 6530	Inlay - metallic - three or more surfaces*	\$195.00
2543, 6543	Onlay - metallic - three surfaces*	\$200.00
2544, 6544	Onlay - metallic - four or more surfaces*	\$215.00
2702	Crown supporting existing partial denture - in addition to crown	\$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	\$125.00
2740	Crown - porcelain/ceramic substrate	\$260.00
2750, 2751, 2752	Crown - porcelain fused to metal*	\$255.00
2790, 2791, 2792	Crown - full cast metal*	\$235.00
2810, 6780	Crown - 3/4 cast metallic*	\$245.00
6210, 6211, 6212	Pontic - cast metal*	\$235.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	\$255.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	\$255.00
6790, 6791, 6792	Crown - abutment - full cast metal*	\$235.00

Other Restorative Services

2910, 2920, 6930	Recementation inlay, crown, bridge	\$5.00
2930, 2931	Prefabricated stainless steel crown	\$20.00
2932	Prefabricated resin crown	\$55.00
2940	Sedative filling	\$10.00
2950, 6973	Core buildup, including any pins	\$50.00
2951	Pin retention - per tooth, in addition to restoration	No Charge
2952, 6970	Cast post & core	\$75.00
2954, 6972	Prefabricated post & core	\$60.00
2960	Labial veneer (laminare) - chairside	\$105.00

Endodontics

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3110, 3120	Pulp cap	\$10.00
3220	Therapeutic pulpotomy	\$25.00
3310	Root canal - anterior	\$135.00
3320	Root canal - bicuspid	\$160.00
3330	Root canal - molar	\$230.00
3346	Root canal - retreatment - anterior	\$165.00
3347	Root canal - retreatment - bicuspid	\$195.00
3348	Root canal - retreatment - molar	\$245.00
3410	Apicoectomy/periradicular surgery - anterior	\$150.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$150.00
3425	Apicoectomy/periradicular surgery - molar - first root	\$160.00
3426	Apicoectomy/periradicular surgery - each additional root	\$70.00
3430	Retrograde filling - per root	\$30.00
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Periodontics

4210	Gingivectomy or gingivoplasty - per quadrant	\$95.00
4211	Gingivectomy or gingivoplasty - per tooth	\$35.00
4240	Gingival flap procedure - including root planing - per quadrant	\$165.00
4249	Clinical crown lengthening - hard tissue	\$140.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$255.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$155.00
4270	Pedicle soft tissue graft procedure	\$165.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$180.00
4341	Periodontal scaling & root planing - per quadrant	\$55.00
4355	Full mouth debridement to enable evaluation and diagnosis	\$30.00
4910	Periodontal maintenance procedures (following active therapy)	\$30.00

Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

4920	Unscheduled dressing change (by other than treating dentist) . . .	No Charge
9951	Occlusal adjustment - limited - per visit	\$15.00
Prosthodontics (Removable)		
5110, 5120	Complete denture (including routine post delivery care)	\$290.00
5130, 5140	Immediate denture (including routine post delivery care)	\$290.00
Partial dentures (including routine post delivery care):		
5211, 5212	Resin base - including clasps, rests, teeth	\$230.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	\$335.00
Repairs and adjustments:		
5410, 5411, 5421, 5422	Denture adjustments	\$15.00
5510, 5610	Repair denture base	\$25.00
5520, 5640	Replace missing or broken teeth -per tooth	\$20.00
5630	Repair or replace clasp	\$25.00
5650	Add tooth to existing partial	\$25.00
5660	Add clasp to existing partial	\$30.00
5710, 5711, 5720, 5721	Rebase denture	\$80.00
5730, 5731, 5740, 5741	Reline denture (chairside)	\$45.00
5750, 5751, 5760, 5761	Reline denture (laboratory)	\$65.00
5820, 5821	Interim partial denture (stayplate)	\$115.00
5850, 5851	Tissue conditioning	\$20.00
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Oral Surgery		
7110, 7120	Extraction - single tooth	\$10.00
7130	Root removal - exposed roots	\$25.00

Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

7210	Surgical removal of erupted tooth	\$50.00
7220	Removal of impacted tooth - soft tissue	\$65.00
7230	Removal of impacted tooth - partially bony	\$90.00
7240	Removal of impacted tooth - completely bony	\$105.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$110.00
7250	Surgical removal of residual tooth roots (cutting procedure)	\$50.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$80.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$115.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption . . .	\$80.00
7285	Biopsy of oral tissue - hard	\$60.00
7286	Biopsy of oral tissue - soft	\$55.00
7310	Alveoplasty in conjunction with extractions - per quadrant	\$45.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	\$60.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	\$75.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	\$145.00
7470	Removal of exostosis - maxilla or mandible	\$110.00
7510	Incision & drainage of intraoral abscess	\$35.00
7960	Frenectomy (separate procedure)	\$80.00

Orthodontic Services

8601	Orthodontic evaluation and consultation	\$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos	\$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months	\$2200.00
8670	Periodic comprehensive orthodontic treatment visit	No Charge
8680	Orthodontic retention	\$407.00

Miscellaneous Services

Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

9110 Palliative (emergency) treatment No Charge

9215 Local anesthesia No Charge

+ Covered services are subject to the plan's exclusions, limitations and plan provisions. Other codes may be used to describe covered services.

* There will be an additional patient charge for the actual cost of gold/high noble metal for these procedures.

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Additional Conditions on Covered Services

General Guidelines For Alternative Procedures In dentistry it is not uncommon for there to be a number of accepted methods of treating a specific dental condition. In those situations in which a *member* selects an *alternative procedure* over the procedure recommended by the *primary care dentist*, the *member* will be responsible for the difference between the *primary care dentist's* usual charges for the recommended procedure and the *alternative procedure*, plus the applicable *patient charge* for the recommended procedure.

When the *primary care dentist* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed (including, but not limited to, a full metal crown, porcelain fused to metal crown or porcelain crown). The *member* is responsible for the applicable *patient charge* for the crown actually placed. The *member* will be responsible for the additional cost of high noble metal, if high noble metal is selected.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be made available to the *member* before treatment begins. It is recommended that the treatment plan be presented to the *member* in writing before treatment begins, to assure that there is no confusion over his or her financial responsibility.

Crowns, Bridges And Dentures A crown is a covered benefit when it is recommended by the *primary care dentist*. The replacement of a crown or bridge is not covered within five (5) years of the original placement under the *plan*.

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by either relining, rebase or repair. Construction of new dentures may not exceed one (1) each in any five (5) year period from the date of previous placement under the *plan*.

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures includes limited follow-up care only for six months, and does not include required future rebasing or relining procedures or a complete new denture.

Multiple Crown/Bridge Unit Treatment Fee When a *member's* recommended treatment plan includes six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the *member* will be responsible for both the usual crown or bridge *patient charge* for each unit of crown or bridge, plus an additional charge per unit shown in the Covered Dental Services and Patient Charges section.

Additional Conditions on Covered Services (Cont.)

Crown Supporting Existing Partial Denture If a crown is placed under an existing partial denture, and the crown must be customized to physically support the metal framework of the partial denture, the *member* will be responsible for the additional *patient charge* for a crown supporting an existing partial denture, as shown in the Covered Dental Services and Patient Charges section, in addition to the *patient charge* for the crown or bridge unit itself. The additional *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* is responsible for the additional charge for a multiple crown/bridge unit treatment plan.

Pediatric Specialty Services If during a *primary care dentist* visit, a *member* under age six (6) is unmanageable, the *member* may be referred to a *participating pediatric specialist dentist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *primary care dentist* for further services. Subsequent referrals to the *participating pediatric specialist dentist*, if any, must first be authorized by The Guardian. Any services performed by a *pediatric specialist dentist* after the *member's* sixth birthday will not be covered, and the *member* will be responsible for the *pediatric specialist dentist's* usual charges.

Second Opinion Consultation A *member* may wish to consult another *dentist* for a second opinion regarding services recommended or performed by his or her *primary care dentist* or by a *participating specialist dentist* through an authorized referral. To have a second opinion consultation covered by The Guardian, the *member* must call or write Member Services for authorization prior to arranging for the second opinion. We only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.

Generally, the Member Services Representative will help the *member* identify a *participating dentist* to perform the second opinion consultation. However, a *member* may request a second opinion with a *non-participating general dentist* or *specialist dentist*. Also, the Member Service Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist*. The *plan's* benefit for a second opinion consultation is limited to fifty dollars (\$50.00). If a *participating dentist* provides the consultation, there is no cost to the *member*. If a *non-participating dentist* provides the consultation, the *member* will be responsible for the portion of the *non-participating dentist's* fee in excess of fifty dollars (\$50.00).

Noble And High Noble Metals The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the *member* will be responsible for the usual *patient charge* for the inlay, onlay, crown or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

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Orthodontic Treatment The *plan* covers orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one course of treatment per *member* per lifetime. Treatment must be preauthorized by The Guardian, and must be performed by a *participating orthodontic specialist dentist*.

Additional Conditions on Covered Services (Cont.)

The Plan covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* will be responsible for an additional charge for each additional month of treatment, based upon the *participating orthodontic specialist dentist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the *plan*. If a *member's* coverage terminates after the fixed banding appliances are inserted, the *participating orthodontist specialist dentist* will continue to honor the contracted fee arrangement in effect when the *member's* fixed banding appliances were inserted. After the termination date, the *member* will be responsible only for the usual *patient charge* for comprehensive orthodontic treatment.

After the termination date, the *member* will also be responsible for the additional monthly amount otherwise paid by the *plan*.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the *member's* responsibility. The benefit for orthodontic retention covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the *member's* responsibility.

If a *member* has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the *plan* provides its standard orthodontic benefit. The *member* will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the *participating orthodontic specialist dentist's* usual and customary charges.

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Limitations On Benefits For Specific Covered Services

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis) - two (2) in any twelve (12) month period.
- Fluoride treatment - up to the 18th birthday - two (2) in any twelve (12) month period.
- Full mouth x-rays - one (1) set in any three (3) year period unless diagnostically necessary.
- Bitewing x-rays - two (2) sets per twelve (12) month period unless diagnostically necessary.
- Panoramic x-rays - one (1) every three (3) years unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one (1) per tooth per three (3) year period.

Additional Conditions on Covered Services (Cont.)

- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one procedure per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one procedure per area in any three (3) year period.
- Periodontal scaling and root planing - one (1) service per quadrant in any twelve (12) month period.
- Periodontal maintenance procedure - following approved, active periodontal therapy (periodontal scaling and root planing or periodontal surgery) performed by a participating Periodontist, one (1) periodontal maintenance procedure by the Periodontist is covered within three (3) to six (6) months following completion of active periodontal therapy.
- Emergency Dental Services when more than fifty (50) miles from the *primary care dentist's* office - limited to a fifty dollar (\$50.00) reimbursement per incident.
- Reline of a complete or partial denture - limited to one (1) per denture during any twelve (12) month period.
- Rebase of a complete or partial denture - limited to one (1) per denture during any twelve (12) month period.
- Second opinion consultation - when approved by The Guardian, a second opinion consultation will be reimbursed up to fifty dollars (\$50.00).

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Exclusions

We won't pay for any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.

We won't pay for dental services performed in a hospital or related hospital fees.

We won't pay for treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered service involving congenitally missing teeth or supernumerary teeth.

We won't pay for any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.

We won't pay for any oral surgery requiring the setting of a fracture or dislocation.

We won't pay for dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

We won't pay for any treatment or appliance requested, recommended or performed, which in the opinion of the *participating dentist* is not necessary for maintaining or improving the *member's* dental health, or which is solely for cosmetic purposes.

Exclusions (Cont.)

We won't pay for precision attachments, stress breakers, magnetic retention or overdenture attachments.

We won't pay for the use of general anesthesia, intramuscular sedation, intravenous sedation, or inhalation sedation, including but not limited to nitrous oxide.

We won't pay for any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

We won't pay for replacement of a lost, missing, or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

We won't pay for any *member* request for specialist services or treatment which can be routinely provided by the *primary care dentist*, or treatment by a specialist without referral from the *primary care dentist* and Managed DentalGuard approval.

We won't pay for treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

We won't pay for any restoration, service, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) replace tooth structure lost due to attrition or abrasion; or (3) splint or stabilize teeth for periodontal reasons.

We won't pay for any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

We won't pay for dental services, other than covered emergency dental services, received from any dentist other than the selected and assigned *primary care dentist*, unless expressly authorized in writing by the *plan*.

We won't pay for cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

We won't pay for treatment which requires the services of a Prosthodontist.

We won't pay for treatment which requires the services of a Pediatric Specialist Dentist, after the *member's* sixth birthday.

We won't pay for consultations for non-covered services.

We won't pay for any procedure not listed as a benefit.

We won't pay for 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.

We won't pay for inlays, onlays, onlays, crowns or fixed bridges started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared, and completed when the final restoration is permanently cemented.)

Exclusions (Cont.)

We won't pay for root canal treatment started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Root canal treatment is considered to be started when the pulp chamber is opened, and completed when the permanent root canal filling material is placed.)

We won't pay for inlays, onlays, crowns or fixed bridges started (as defined above) by a *non-participating dentist*. This exclusion will not apply to services that were covered under the *plan* as *emergency dental services*.

We won't pay for root canal treatment started (as defined above) by a *non-participating dentist*. This exclusion will not apply to services that were covered under the *plan* as *emergency dental services*.

We won't pay for dentures, or orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan*. (Dentures are considered to be started when the impressions are taken. Orthodontic treatment is considered to be started when the teeth are banded.)

We won't pay for extractions performed solely to facilitate orthodontic treatment.

We won't pay for extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

We won't pay for orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.

We won't pay for procedures performed to facilitate non-covered services, including but not limited to root canal therapy to facilitate either hemisection or root amputation, and osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

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We won't pay for procedures, appliances or devices to guide minor tooth movement or to correct or control harmful habits.

We won't pay for any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

We won't pay for re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

We won't pay for replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

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Converting This Group Dental Insurance

Important Notice This section applies only to dental expense coverages. In this section these coverages are referred to as "group dental benefits."