Guardian Dental DHMO

IBEW Local 18 Health & Welfare Trust

Group Plan #: 00456998

Guardian Dental DHMO.

Choosing a dental plan for you and your family is an important decision. Both Guardian Dental plans offered through the IBEW Local 18 Health & Welfare Trust provide coverage that will help protect and maintain you and your family's oral health.

Read below to learn more about your DHMO dental plan.

Managed Dental Care (DHMO) Plan

With this DHMO plan, you will always know your costs up front. Your Patient Charges Sheet shows you how much you'll pay for all covered services, so you will always know what to expect and can plan ahead.

It's Easy to Use Your DHMO Plan:

- Member-Level ID card Sent to Your Home
- Each Family Member Can Choose Their Own Primary Care Dentist and should seek all care from that dentist.
- No Office Visit Copay
- No Deductibles
- No Annual Maximum Benefits
- 100% Coverage for Cleanings, Exams, Fluoride & X-Rays to help keep you and your family healthy.
- Additional Benefits: Adult & Child Ortho, Veneers, Brush Biopsies, White Fillings and Crowns

Please refer to your Patient Charges Sheet for more information about your plan.

Compare Both Dental Plans

Still not sure which plan is right for you? Check out this example of how both plans cover the cost of a root canal:

Average cost of a root canal and associated dental work*	
	Managed Dental Care (DHMO) Member At Primary Care Dentist
You Pay	$145

Exclusions & Limitations

DHMO: This policy provides dental coverage only. This policy provides managed care dental benefits through a network of participating general dentists and specialty care dentists. Except for limited emergency services, benefits will be provided for services provided by the primary care dentist selected by the member. The member must pay the primary care dentist a patient charge/copayment for most covered services. No benefits will be paid for treatment by a specialist unless the patient is referred by his or her primary care dentist and the referral is approved under the policy. Only those services listed in the policy's schedule of benefits are covered. Certain services are subject to frequency or other periodic limitations. Where orthodontic benefits are specifically included, the policy provides for one course of comprehensive treatment per member. Unless specifically included, the Managed Dental Care policy does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed Dental Care policy. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The applicable Managed Dental Care documents are the final arbiter of coverage .See your Certificate for complete specifics of all Exclusions and Limitations. All products, unless otherwise noted, are underwritten by The Guardian Life. Insurance Company of America ("Guardian") or one of the following wholly-owned Guardian subsidiaries: Managed Dental Care (CA). Any reference to a specific product type, including but not limited to "DHMO" or "Prepaid" is not intended to refer to a specific state license designation, but rather is merely intended to refer to a general product design. Such DHMO, or prepaid products, are licensed in the applicable jurisdiction. Please see the applicable policy forms for details. In the event of conflict between this brochure and the policy forms, the policy forms shall control.

Guardian®

*Illustrative example only. See your plan for specific details regarding covered services. Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY or its subsidiaries. Products not available in all states. Policy limitations and exclusions apply. Plan documents are the final arbiter of coverage. Policy Form#GP-1-DG6, et al.

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Find A Primary Care Provider: www.GuardianAnytime.com.

This plan uses the Managed Dental Care Network for your DHMO plan option.

BENEFITS COVERED	Benefits Paid for Care at DHMO Providers Only
YOUR RESPONSIBILTIES	**You are responsible for the patient charge copay for each service. Your plan covers the rest! Common Services & Patient Charges shown below.**
	IN-NETWORK ONLY
ANNUAL DEDUCTIBLE	None
PREVENTIVE CARE	**You Pay:**
Cleanings	$0
Frequency:	2 per 12 Months[1]
Oral Exams	$0
Fluoride Treatments	$0
Limits:	No Age Limits
Periodontal Maintenance	$15
Frequency:	2 per 12 Months[1]
X-Rays	$0
BASIC CARE	
General Anesthesia	Restrictions Apply
Fillings[2]	$0
Periodontal Surgery	**$60-155**
Root Canal	**$70-140**
Scaling & Root Planing	**$15-25**
Sealants (per tooth)	**$0**
Simple Extractions	**$10**
Surgical Extractions	**$35-85**
MAJOR CARE	
Bridges & Dentures	$90-140
Single Crowns[3]	$95
Inlays, Onlays & Veneers[3]	$40-80
Repair & Maintenance of Crowns, Bridges, Dentures	**$0**
Cosmetic Care	**$165 per arch**
Implants	Not Covered
	See Patient Charges Sheet for Full List of Covered Services
ANNUAL MAXIMUM	None
ADULT & CHILD ORTHODONTIA	$1,500 - $2,800

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your ember ID (social security number) and your plan number: **00456998**.

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

1. Additional cleanings are available for an additional co-pay).. 2. Fillings – restrictions or additional cost may apply to composite fillings. 3. Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage.

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MANAGED DENTALGUARD ORTHODONTIC BENEFITS

Managed DentalGuard Orthodontic Plan Schedule – Option W

CDT Codes	Covered Services and Patient Charges	Patient Charges	Orthodontics In Progress
	Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition **		
D8080	Comprehensive orthodontic treatment of the adolescent dentition **	Child: $1500	***
D8090	Comprehensive orthodontic treatment of the adult dentition **	Adult: 2800	***
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	250	***
D8670	Periodic orthodontic treatment visit	0	***
D8680	Orthodontic retention	400	***
	Broken appointment	25	***

Current Dental Terminology (CDT) © American Dental Association (ADA) v.08192

** Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above and employee or spouse. A Member's age is determined on the date of banding.

*** Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Plan Schedule and were started but not completed prior to the Member's eligibility to receive benefits under this plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation retention services would also be at 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this plan, the Patient Charge for orthodontic retention is equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan Booklet and the Manual.

The Plan Covers:

- Orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one (1) course of treatment per Member. We must preauthorize treatment, and it must be performed by a Participating Orthodontic Specialist Dentist.
- Up to twenty-four (24) months of comprehensive orthodontic treatment.
- Treatment plan and records, including initial records and any interim and final records.
- Comprehensive orthodontic treatment, including the fixed banding appliances and related visits only.
- Retention services following a course of comprehensive orthodontic treatment that was covered under this Plan.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the 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 fee.

This Plan Does Not Cover:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under MDG.
- Orthodontic treatment performed by any dentist other than a Participating Orthodontic Specialist Dentist.
- Limited orthodontic treatment and interceptive (Phase I) treatment.
- Treatment beyond twenty-four (24) months. (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.)
- Except as described under treatment in progress – orthodontic treatment, 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 Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment.
- Orthodontic services after a Member's coverage terminates.
- Any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or linqual brackets.
- Procedures, appliances or devices to (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.
- Extractions performed solely to facilitate orthodontic treatment.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- If a Member transfers to another Participating Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

CDT Codes ++	Covered Dental Services	Patient Charges
D0999	Office visit during regular hours, general dentist only *	$0
	Evaluations	
D0120	Periodic oral examination – established patient	0
D0140	Limited oral evaluation – problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation – new or established patient	0
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)	0
D0180	Comprehensive periodontal evaluation – new or established patient	0
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Intraoral – complete series (including bitewings)	0
D0220	Intraoral – periapical first film	0
D0230	Intraoral – periapical each additional film	0
D0240	Intraoral – occlusal film	0
D0270	Bitewing – single film	0
D0272	Bitewings – two films	0
D0273	Bitewings – three films	0
D0274	Bitewings – four films	0
D0277	Vertical bitewings – 7 to 8 films	0
D0330	Panoramic film	0
	Tests and Examinations	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	Dental Prophylaxis	
D1110	Prophylaxis – adult, for the first two services in any 12-month period + #	0
D1120	Prophylaxis – child, for the first two services in any 12-month period + #	0
D1999	Prophylaxis – adult or child, for each additional service in same 12-month period + #	60
	Topical Fluoride Treatment (Office Procedure)	
D1203	Topical application of fluoride (prophylaxis not included) – child, for the first two services in any 12-month period + =	0
D1204	Topical application of fluoride (prophylaxis not included) – adult, for the first two services in any 12-month period + =	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12-month period + =	0
D2999	Topical fluoride (adult or child), each additional service in the same 12-month period + =	20
	Other Preventive Services	
D1310	Nutritional counseling for control of dental disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant – per tooth (molars) ^	0
D9999	Sealant – per tooth (non-molars) ^	35
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer – fixed - unilateral	0
D1515	Space maintainer – fixed - bilateral	0
D1525	Space maintainer – removable - bilateral	0
D1550	Re-cementation of space maintainer	0
D1555	Removal of fixed space maintainer	0
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam – one surface, primary or permanent	0
D2150	Amalgam – two surfaces, primary or permanent	0
D2160	Amalgam – three surfaces, primary or permanent	0
D2161	Amalgam – four or more surfaces, primary or permanent	0
	Resin-Based Composite Restorations - Direct	
D2330	Resin-based composite – one surface, anterior	0
D2331	Resin-based composite – two surfaces, anterior	0
D2332	Resin-based composite – three surfaces, anterior	0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	0
D2390	Resin-based composite crown, anterior	0
D2391	Resin-based composite – one surface, posterior	0
D2392	Resin-based composite – two surfaces, posterior	0
D2393	Resin-based composite – three surfaces, posterior	0
D2394	Resin-based composite – four or more surfaces, posterior	0
	Inlay/Onlay Restorations ^^	
D2510	Inlay – metallic – one surface **	60
D2520	Inlay – metallic – two surfaces **	75
D2530	Inlay – metallic – three or more surfaces **	75
D2542	Onlay – metallic – two surfaces **	80
D2543	Onlay – metallic – three surfaces **	80
D2544	Onlay – metallic – four or more surfaces **	80
D2610	Inlay – porcelain/ceramic – one surface	60
D2620	Inlay – porcelain/ceramic – two surfaces	75
D2630	Inlay – porcelain/ceramic – three or more surfaces	75
D2642	Onlay – porcelain/ceramic – two surfaces	80
D2643	Onlay – porcelain/ceramic – three surfaces	80
D2644	Onlay – porcelain/ceramic – four or more surfaces	80

CDT Codes ++	Covered Dental Services	Patient Charges
	Crowns – Single Restorations Only ^^	
D2740	Crown – porcelain/ceramic substrate	$100
D2750	Crown – porcelain fused to high noble metal **	95
D2751	Crown – porcelain fused to predominantly base metal	95
D2752	Crown – porcelain fused to noble metal	95
D2780	Crown – ¾ cast high noble metal **	85
D2781	Crown – ¾ cast predominantly base metal	85
D2782	Crown – ¾ cast noble metal	85
D2783	Crown – ¾ porcelain/ceramic	85
D2790	Crown – full cast high noble metal **	95
D2791	Crown – full cast predominantly base metal	95
D2792	Crown – full cast noble metal	95
D2794	Crown – titanium	95
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	0
D2915	Recement cast or prefabricated post and core	0
D2920	Recement crown	0
D2930	Prefabricated stainless steel crown – primary tooth	10
D2931	Prefabricated stainless steel crown – permanent tooth	10
D2932	Prefabricated resin crown	20
D2933	Prefabricated stainless steel crown with resin window	20
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	20
D2940	Sedative filling	0
D2950	Core buildup, including any pins	20
D2951	Pin retention – per tooth, in addition to restoration	0
D2952	Post and core in addition to crown, indirectly fabricated	30
D2953	Each additional indirectly fabricated post – same tooth	10
D2954	Prefabricated post and core in addition to crown	25
D2957	Each additional prefabricated post – same tooth	8
D2960	Labial veneer (resin laminate) – chairside	40
D2970	Temporary crown (fractured tooth)	15
D2971	Additional procedures to construct new crown under existing partial denture framework	125
	Pulp Capping	
D3110	Pulp cap – direct (excluding final restoration)	0
D3120	Pulp cap – indirect (excluding final restoration)	0
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	10
D3221	Pulpal debridement, primary and permanent teeth	10
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	10
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	15
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	15
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-up Care)	
D3310	Root canal, anterior (excluding final restoration)	70
D3320	Root canal, bicuspid (excluding final restoration)	80
D3330	Root canal, molar (excluding final restoration)	140
D3331	Treatment of root canal obstruction; non-surgical access	0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	70
D3333	Internal root repair of perforation defects	40
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy – anterior	80
D3347	Retreatment of previous root canal therapy – bicuspid	95
D3348	Retreatment of previous root canal therapy – molar	150
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery – anterior	90
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	95
D3425	Apicoectomy/periradicular surgery – molar (first root)	100
D3426	Apicoectomy/periradicular surgery (each additional root)	40
D3430	Retrograde filling – per root	15
D3950	Canal preparation and fitting of preformed dowel or post	20
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	60
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	20
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	105
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	35
D4249	Clinical crown lengthening – hard tissue	85
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	155
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	95
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	100
D4271	Free soft tissue graft procedure (including donor site surgery)	110
D4273	Subepithelial connective tissue graft procedures, per tooth	120

CDT Codes ++	Covered Dental Services	Patient Charges
	Non-Surgical Periodontal Service	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$25
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	15
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	15
	Other Periodontal Services	
D4910	Periodontal maintenance, for the first two services in any 12-month period + #	15
D4920	Unscheduled dressing change (by someone other than treating dentist)	0
D4999	Periodontal maintenance, each additional service in same 12-month period + #	60
	Complete Dentures (Including Routine Post-Delivery Care)	
D5110	Complete denture – maxillary	110
D5120	Complete denture – mandibular	110
D5130	Immediate denture – maxillary	110
D5140	Immediate denture – mandibular	110
	Partial Dentures (Including Routine Post-Delivery Care)	
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	90
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	90
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	140
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	140
	Adjustments to Dentures	
D5410	Adjust complete denture – maxillary	5
D5411	Adjust complete denture – mandibular	5
D5421	Adjust partial denture – maxillary	5
D5422	Adjust partial denture – mandibular	5
	Repairs To Complete Dentures	
D5510	Repair broken complete denture base	0
D5520	Replace missing or broken teeth – complete denture (each tooth)	0
	Repairs To Partial Dentures	
D5610	Repair resin denture base	0
D5620	Repair cast framework	0
D5630	Repair or replace broken clasp	0
D5640	Replace broken teeth – per tooth	0
D5650	Add tooth to existing partial denture	0
D5660	Add clasp to existing partial denture	0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	0
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	0
D5711	Rebase complete mandibular denture	0
D5720	Rebase maxillary partial denture	0
D5721	Rebase mandibular partial denture	0
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	0
D5731	Reline complete mandibular denture (chairside)	0
D5740	Reline maxillary partial denture (chairside)	0
D5741	Reline mandibular partial denture (chairside)	0
D5750	Reline complete maxillary denture (laboratory)	0
D5751	Reline complete mandibular denture (laboratory)	0
D5760	Reline maxillary partial denture (laboratory)	0
D5761	Reline mandibular partial denture (laboratory)	0
	Interim Prosthesis	
D5820	Interim partial denture (maxillary)	45
D5821	Interim partial denture (mandibular)	45
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	0
D5851	Tissue conditioning, mandibular	0
	Fixed Partial Denture Pontics ^^	
D6210	Pontic – cast high noble metal **	90
D6211	Pontic – cast predominantly base metal	90
D6212	Pontic – cast noble metal	90
D6214	Pontic – titanium	90
D6240	Pontic – porcelain fused to high noble metal **	90
D6241	Pontic – porcelain fused to predominantly base metal	90
D6242	Pontic – porcelain fused to noble metal	90
D6245	Pontic – porcelain/ceramic	90
	Fixed Partial Denture Retainers – Inlays/Onlays ^^	
D6600	Inlay – porcelain/ceramic – two surfaces	75
D6601	Inlay – porcelain/ceramic – three or more surfaces	75
D6602	Inlay – cast high noble metal, two surfaces **	75
D6603	Inlay – cast high noble metal, three or more surfaces **	75
D6604	Inlay – cast predominantly base metal, two surfaces	75

CDT Codes ++	Covered Dental Services	Patient Charges
	Fixed Partial Denture Retainers – Inlays/Onlays ^^ (continued)	
D6605	Inlay – cast predominantly base metal, three or more surfaces	$75
D6606	Inlay – cast noble metal, two surfaces	75
D6607	Inlay – cast noble metal, three or more surfaces	75
D6608	Onlay – porcelain/ceramic, two surfaces	80
D6609	Onlay – porcelain/ceramic, three or more surfaces	80
D6610	Onlay – cast high noble metal, two surfaces **	80
D6611	Onlay – cast high noble metal, three or more surfaces **	80
D6612	Onlay – cast predominantly base metal, two surfaces	80
D6613	Onlay – cast predominantly base metal, three or more surfaces	80
D6614	Onlay – cast noble metal, two surfaces	80
D6615	Onlay – cast noble metal, three or more surfaces	80
D6624	Inlay – titanium	75
D6634	Onlay – titanium	75
	Fixed Partial Denture Retainers – Crowns ^^	
D6740	Crown – porcelain/ceramic	100
D6750	Crown – porcelain fused to high noble metal **	95
D6751	Crown – porcelain fused to predominantly base metal	95
D6752	Crown – porcelain fused to noble metal	95
D6780	Crown – ¾ cast high noble metal **	85
D6781	Crown – ¾ cast predominantly base metal	85
D6782	Crown – ¾ cast noble metal	85
D6783	Crown – ¾ porcelain/ceramic	85
D6790	Crown – full cast high noble metal **	95
D6791	Crown – full cast predominantly base metal	95
D6792	Crown – full cast noble metal	95
D6794	Crown – titanium	95
	Other Fixed Partial Denture Services	
D6930	Recement fixed partial denture	0
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	30
D6972	Prefabricated post and core in addition to fixed partial denture retainer	25
D6973	Core build up for retainer, including any pins	20
D6976	Each additional cast post – same tooth	10
D6977	Each additional prefabricated post – same tooth	8
D6999	Multiple crown and bridge unit treatment plan – per unit, six or more units per treatment plan ^^	125
	Extractions	
D7111	Extraction, coronal remnants – deciduous tooth	10
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10
	Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	35
D7220	Removal of impacted tooth – soft tissue	50
D7230	Removal of impacted tooth – partially bony	70
D7240	Removal of impacted tooth – completely bony	80
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	85
D7250	Surgical removal of residual tooth roots (cutting procedure)	40
D7261	Primary closure of a sinus perforation	250
	Other Surgical Procedures	
D7280	Surgical access of an unerupted tooth	90
D7283	Placement of device to facilitate eruption of impacted tooth	35
D7285	Biopsy of oral tissue – hard (bone, tooth)	45
D7286	Biopsy of oral tissue – soft	40
D7288	Brush biopsy – transepithelial sample collection	65
	Alveoloplasty – Surgical Preparation Of Ridge For Dentures	
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	35
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	16
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	45
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	30
	Surgical Excision Of Intra-Osseous Lesions	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	60
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	110
	Excision Of Bone Tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)	75
D7472	Removal of torus palatinus	75
D7473	Removal of torus mandibularis	75
	Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue	25
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	30
	Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	60
D7963	Frenuloplasty	100

CDT Codes ++	Covered Dental Services	Patient Charges
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
D9120	Fixed partial denture sectioning	15
D9215	Local anesthesia	0
D9220	Deep sedation/general anesthesia – first 30 minutes +++	195
D9221	Deep sedation/general anesthesia – each additional 15 minutes +++	75
D9241	Intravenous conscious sedation/analgesia – first 30 minutes +++	195
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes +++	75
	Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	30
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	0
D9440	Office visit – after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
	Miscellaneous Services	
D9951	Occlusal adjustment – limited	0
D9971	Odontoplasty – one to two teeth	10
D9972	External bleaching – per arch	165
	Broken appointment	25

Current Dental Terminology (CDT) © American Dental Association (ADA)

+ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12-month period. For each additional service in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan booklet and the Manual (including the Quality Management retrospective review). Other codes may be used to describe Covered Services.

***** The Member will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is an "M". The Plan will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is a "G". The ID Card and Eligibility Report will indicate if the Office Visit Fee is $5 or $10.

Routine prophylaxis or periodontal maintenance procedure - a total of four services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a participating periodontal Specialist if done within three to six months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a participating periodontal Specialist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.

= Fluoride Treatment - a total of four services in any 12-month period.

^ Sealants are limited to permanent teeth up to the 16th birthday.

****** If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.

^^ The Patient Charge for these services is per unit.

+++ Procedure codes D9220, D9221, D9241 and D9242 are limited to a participating oral surgery Specialist. Additionally, these services are only covered in conjunction with other covered surgical services.

Underwritten by: (IL) - First Commonwealth Insurance Company, (MO) - First Commonwealth of Missouri, (IN) - First Commonwealth Limited Health Services Corporation, (MI) - First Commonwealth Inc., (CA) - Managed Dental Care, (TX) - Managed DentalGuard, Inc. (DHMO), (NJ) - Managed DentalGuard, Inc., (FL, NY) - The Guardian Life Insurance Company of America. All First Commonwealth, Managed DentalGuard, Inc., and Managed Dental Care entities referenced are wholly-owned subsidiaries of The Guardian Life Insurance Company of America. Limitations and exclusions apply. Plan documents are the final arbiter of coverage.

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Managed DentalGuard (DHMO)
California
Fine Print

For MDG Plans U10G, U11G, U20G, U21G, U30G, U31G, U40G, U41G, U50G, U51G, U60G, U61G, U10M, U11M, U20M, U21M, U30M, U31M, U40M, U41M, U50M, U51M, U60M, and U61M.

Managed DentalGuard (Guardian, First Commonwealth, Managed Dental Care, Managed DentalGuard, MDG) (Us; We) combines broad dental coverage with a number of cost-saving features for you and your family. Many procedures are covered at no cost to you. There are no claim forms to complete, no deductibles and no yearly maximums.

Emergency Dental Services (Applicable in CA, CO, FL, NJ and OH only)
The MDG network also provides for emergency dental services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her selected Primary Care Dentist (PCD), who will arrange for such care.

A Member may require emergency dental services when he or she is unable to obtain services from his or her PCD. The Member should contact his or her PCD for a referral to another Dentist or contact Us for an authorization to obtain services from another Dentist. The Member must submit to Us: (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. We will reimburse the Member for the cost of covered emergency dental services, less the applicable Patient Charge(s).

When emergency dental services are provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us, coverage is limited to the benefit for palliative treatment (code D9110)

General Guidelines For Alternative Procedures
There may be a number of accepted methods of treating a specific dental condition. When a Member selects an alternative procedure over the service recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended service and the alternative procedure. He or she will also have to pay the applicable Patient Charge for the recommended service.

When the Member selects a posterior composite restoration as an alternative procedure to a recommended amalgam restoration, the alternative procedure policy does not apply. When the Member selects an extraction as an alternative procedure to root canal therapy, the alternative procedure does not apply.

When the PCD recommends a crown, the alternative procedure policy does not apply, regardless of the type of crown placed. The type of crown includes but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The Member must pay the applicable Patient Charge for the crown actually placed.

The Plan provides for the use of noble, high noble and base metals for inlays, onlays, crowns, and fixed bridges. When high noble metal is used, the Member will pay an additional amount for the actual cost of the high noble metal. In addition, the Member will pay the usual Patient Charge for the inlay, onlay, crown or fixed bridge. The total Patient Charges for the high noble metal may not exceed the actual lab bill for the service.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the Member before treatment begins. The PCD should present the Member with the treatment plan in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

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General Guidelines For Alternative Treatment By The PCD

There may be a number of accepted methods for treating a specific dental condition. In all cases where there are more than one course of treatment available, a full disclosure of all the options must be given the Member before treatment begins. The PCD should present the Member with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the Member should pay, and to fully document informed consent.

- If any of the recommended alternate services are selected by the Member and not covered under the Plan, then the Member must pay the PCD's usual charge for the recommended alternate service.
- If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate service for the condition being treated), then the PCD is not obliged to provide that treatment even if it is a covered service under the Plan.

Members can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the PCD or Participating Specialty Care Dentist.

Crowns, Bridges and Dentures

A crown is a covered service when it is recommended by a PCD. The replacement of a bridge is not covered within 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 reline, rebase or repair. Construction of new dentures may not exceed one each in any 5-year period from the date of previous placement under the Plan. Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the PCD.

Multiple Crown and Bridge Unit Treatment Fee

When a Member's 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 the Patient Charge for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

Pediatric Specialty Services

If, during a PCD visit, a Member under age eight (8) is unmanageable, the PCD may refer the Member to a Participating Pediatric Specialty Care Dentist for the current treatment plan only. Following completion of the approved pediatric treatment plan, the Member must return to the PCD for further services. If necessary, We must first authorize subsequent referrals to the Participating Specialty Care Dentist. Any services performed by a Pediatric Specialty Care Dentist after the Member's eighth (8th) birthday will not be covered, and the Member will be responsible for the Pediatric Specialty Care Dentist's usual fees.

Second Opinion Consultation (Applicable in CA only):

A Member may wish to consult another Dentist for a second opinion regarding services recommended or performed by: (a) his or her PCD; or (b) a Participating Specialty Care Dentist through an authorized referral. To have a second opinion consultation covered by Us, the Member must call or write Member Services for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the Plan.

Plan will review and approve second opinions if there are questions regarding the following;

- The reasonableness or necessity of a recommended surgical procedure.
- Diagnosis or plan of care, including once care has been initiated.
- Treatment in progress.

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Authorization or denial will be provided in an expeditious manner. The Member will be notified in writing if the second opinion is denied and reason for denial will be included. The Member will have the right to file a grievance with the Plan.

A Member Services Representative will help the Member identify a Participating Dentist to perform the second opinion consultation. The Member may request a second opinion with a Non-Participating General Dentist or Specialty Care Dentist. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist. Authorizations for second opinions are valid for sixty (60) days from the date of approval. Once the second opinion consultation is completed and the Second Opinion Form is returned to the Member Services Representative, you and your dentist will receive a copy of the findings and recommendations.

You may appeal a denial for a second opinion to:

Managed Dental Care (MDC)
Grievance Committee
21255 Burbank Boulevard Suite 120
Woodland Hills, CA 91367

The appeal will be reviewed through the Plan's grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist. All appeals for the necessity of a second opinion are reviewed by a dentist having appropriate clinical background, as determined by MDC's Dental Director. Second opinions that have not received prior authorization and are for non-covered services are excluded.
MDC has a written policy describing the timeline for second opinions and how we administer the second opinion program. You may request a complete copy of MDC's written policy by contacting the Member Services Department at 800-273-3330, or by mail at P.O. Box 4391, Woodland Hills, CA 91367.

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 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.

General Anesthesia / IV Sedation
General anesthesia / IV sedation . General anesthesia or IV sedation is limited to services provided by a Participating Oral Surgery Specialty Care Dentist. Not all Participating Oral Surgery Specialty Care Dentists offer these services. The Member is responsible to identify and receive services from a Participating Oral Surgery Specialty Care Dentist willing to provide general anesthesia or IV sedation.

Office Visit Charges
Office visit Patient Charges that are the Member's responsibility after this Group Plan has been in effect for three (3) full years, will be paid to the PCD by Us.

Orthodontic Treatment
The Plan covers orthodontic services as listed under Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per Member. We must preauthorize treatment, and treatment must be performed by a Participating Orthodontic Specialty Care Dentist.

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The Plan covers, up to, twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (24) months is necessary, the Member will be responsible for each additional month of treatment, based upon the Participating Orthodontic Specialty Care Dentist's contracted fee.

Except as described under the Treatment in Progress. Orthodontic Treatment and Treatment in Progress. Takeover Benefit for Orthodontic Treatment, 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 Orthodontic Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the Participating Orthodontic Specialty Care Dentist for services after the termination date. Retention services are covered at the Patient Charge shown in the Covered Dental Services and Patient Charges section only following a course of comprehensive orthodontic treatment started and completed under this Plan.

If a Member transfers to another Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member must pay any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

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. The Member must pay for any additional fixed or removable appliances. The benefit for orthodontic retention is limited to twelve (12) months and 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 non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. The Member must pay any additional costs for the use of optional materials.

If a Member has orthodontic treatment associated with orthognathic surgery (a Non-Covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member must pay any additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialty Care Dentist's usual fee.

Treatment in Progress (Applicable in CA, CO, FL, NJ, NY and OH only):
A Member may choose to have a Participating Dentist complete an inlay, onlay, crown, fixed bridge, denture, root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges Section; and (2) was started but not completed prior to the Member's eligibility to receive benefits under this Plan. The Member is responsible to identify, and transfer to, a Participating Dentist willing to complete the procedure at the Patient Charge described in this section.

- Restorative Treatment. Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan, have a Patient Charge equal to 85% of the Participating General Dentist's usual fee. (There is no additional charge for high noble metal.)
- Endodontic Treatment. Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating General or Specialty Care Dentist who is willing to complete the procedure at a Patient Charge equal to 85% of Participating Dentist's usual fee.
- Orthodontic Treatment. Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment, including retention, at a Patient Charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Treatment in Progress. Takeover Benefit for Orthodontic Treatment (Orthodontic Takeover Treatment-in-Progress) section.

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Treatment-in-Progress. Takeover Benefit for Orthodontic Treatment (Not Applicable in MI):
The Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment (Orthodontic Takeover Treatment-In-Progress) provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental HMO plan with the current treating Orthodontist, after this Plan becomes effective.

A Member may be eligible for the Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment only if:

- The Member was covered by another dental HMO plan just prior to the effective date of this Plan and had started comprehensive orthodontic treatment (D8070, D8080, or D8090) with a Participating Network Orthodontist under the prior dental HMO plan;
- The Member has such orthodontic treatment in progress at the time this Plan becomes effective;
- The Member continues such orthodontic treatment with the treating Orthodontist;
- The Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating Orthodontist raised fees due to the termination of the prior dental HMO plan; and
- A Treatment-in-Progress. Takeover Benefit for Orthodontic Treatment Form, completed by the treating Orthodontist, is submitted to Us within 6 months of the effective date of this Plan.

The benefit amount will be calculated based on: (i) the number of remaining months of comprehensive orthodontic treatment; and (ii) the amount by which the Member's payment responsibility has increased as a result of the treating Orthodontist's raised fees, up to a maximum benefit of $500 per Member.

The Member will be responsible to have the treating Orthodontist complete a Treatment-in-Progress. Takeover Benefit for Orthodontic Treatment Form and submit it to Us. The Member has 6 months from the effective date of this Plan to have the Form submitted to Us in order to be eligible for the Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment. We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under this Plan is terminated.

This benefit is only available to Members that were covered under the prior dental HMO dental plan and are in comprehensive orthodontic treatment with a Participating Network Orthodontist when this Plan becomes effective with Us. It will not apply if the comprehensive orthodontic treatment was started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another Orthodontist. This benefit applies to Members of new Plans only. It does not apply to Members of existing Plans. And it does not apply to persons who become newly eligible under the Group after the effective date of this Plan.

The benefit is only available to Members in comprehensive orthodontic treatment (D8070, D8080, or D8090). It does not apply to any other orthodontic services. Additionally, we will only cover up to a total 24 months of comprehensive orthodontic treatment.

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Limitations

NOTE: Time limitations for a service are determined from the date that service was last rendered under this plan.
The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

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

1. Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) - a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
2. Fluoride treatment (D1203, D1204, D1206, D2999) - four (4) in any twelve (12) month period.
3. Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to one (1) in any two (2) year period on or after the 40th birthday.
4. Full mouth x-rays -one (1) set in any three (3) year period.
5. Bitewing x-rays - two (2) sets in any twelve (12) month period.
6. Panoramic x-rays - one (1) set in any three (3) year period.
7. Sealants - limited to permanent teeth, up to the 16th birthday - one (1) per tooth in any three (3) year period.
8. Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (3) year period.
9. Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
10. Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
11. Emergency dental services when more than fifty (50) miles from the PCD's office - limited to a $50.00 reimbursement per incident. (Not applicable in NY and MI).
12. Emergency dental services when provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by MDG - limited to the benefit for palliative treatment (code D9110) only. (Not applicable in NY).
13. Reline of a complete or partial denture - (one) 1 per denture in any twelve (12) month period.
14. Rebase of a complete or partial denture - (one) 1 per denture in any twelve (12) month period.
15. Second Opinion Consultation - When approved by Us, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan. The office visit Patient Charge will apply. (Applicable in CA only).

Exclusions

We won't pay for:

1. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
2. Dental services performed in a hospital, surgical center, or related hospital fees.
3. Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered service involving (a) congenitally missing or (b) supernumerary teeth. (Not applicable in FL, MO, NY or NJ).
4. Any histopathological examination or other laboratory charges.
5. Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
6. Any oral surgery requiring the setting of a fracture or dislocation.
7. Placement of osseous (bone) grafts.
8. Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
9. Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the Participating Dentist is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes. (Not applicable in NY).
10. Precision attachments, stress breakers, magnetic retention or overdenture attachments.

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11. The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
12. Any procedure or treatment method which does not meet professionally recognized standards of dental practice.
13. Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
14. Replacement or repair of prosthetic appliances damaged due to the neglect of the Member. (Not applicable in FL).
15. Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD, or (b) treatment by a Specialist without a referral by the PCD and approval from Us.
16. Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits.
17. Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons; (d) realign teeth.
18. Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
19. Dental services, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's assigned PCD, unless We had provided written authorization.
20. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
21. Treatment which requires the services of a Prosthodontist.
22. Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th birthday.
23. Consultations for non-covered services.
24. Any procedure not specifically listed in the Covered Dental Services and Patient Charges section.
25. Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
26. Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. Restorative Treatment. (Inlays, onlays, crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.) (Not applicable in MI).
27. Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.) (Not applicable in MI and NJ).
28. Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. Orthodontic Treatment - Orthodontic Treatment and Treatment in Progress. Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.) (Not applicable in MI and NY).
29. Inlays, onlays, crowns, fixed bridges or dentures started by a Non-Participating Dentist. (Inlays, onlays, crowns, and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the Plan as Emergency Dental Services. (Not applicable in MI and NY).
30. Root canal treatment started by a Non-Participating Dentist. (Root canal treatment is considered to be started when the pulp chamber is opened.) This exclusion will not apply to services that were started and which were covered, under the Plan as Emergency Dental Services. (Not applicable in MI).
31. Orthodontic treatment started by a Non-Participating Dentist while the Member is covered under this plan. (Orthodontic treatment is considered to be started when the teeth are banded.)
32. Extractions performed solely to facilitate orthodontic treatment.
33. Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
34. Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
35. Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
36. Procedures performed to facilitate Non-Covered Services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemi-section or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
37. Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
38. 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.
39. Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
40. Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.