

Covered Dental Services and Patient Charges – U10TXI03

The services covered by this Plan are named in this list. If a service, treatment or procedure is not on this list, it is not a covered service. All services must be provided by the assigned PCD.

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 and Conditions on Covered Dental Services and Exclusions.

There is a limit on the total amount of Patient Charges a Member who is under age 19 must pay each calendar year for pediatric essential health benefits as determined by Texas. The limit is \$350.00 for each such Member. Once this limit is reached the plan waives Patient Charges for such benefits for the rest of the calendar year for such Member. But if two or more such Members meet the limit of \$700.00 in a calendar year, the plan waives the Patient Charges for such benefits for all other such Members for the rest of the calendar year.

The Patient Charges listed this section are only valid for covered services that are: (1) started and completed under this Plan, and (2) rendered by Participating Dentists in the State of Texas.

CDT Code++	Covered Services and Patient Charges	Patient Charge
D0100- D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - 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
D0210	Intraoral - complete series of radiographic images	\$0
D0220	Intraoral - periapical first radiographic image	\$0
D0230	Intraoral - periapical each additional radiographic image	\$0
D0240	Intraoral - occlusal radiographic image	\$0
D0270	Bitewing - single radiographic image	\$0
D0272	Bitewings - two radiographic images	\$0
D0273	Bitewings - three radiographic images	\$0
D0274	Bitewings - four radiographic images	\$0
D0277	Vertical bitewings - 7 to 8 radiographic images	\$0
D0330	Panoramic radiographic image	\$0
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
D0999	Office visit during regular hours, general dentist only	\$15
D1000- D1999	II. PREVENTIVE	
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
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 application of fluoride varnish, for the first two services in any 12-month period+=	\$12
D1208	Topical application of fluoride, for the first two services in any 12-month period +=	\$0

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D2999	Topical fluoride (adult or child), each additional service in the same 12-month period+=	\$20
D1310	Nutritional counseling for control of dental diseases	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant - per tooth (molars) ##	\$14
D9999	Sealant - per tooth (non-molars) ##	\$35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth ##	\$14
D1510	Space maintainer - fixed - unilateral	\$75
D1515	Space maintainer - fixed - bilateral	\$110
D1525	Space maintainer - removable - bilateral	\$110
D1550	Re-cementation of space maintainer	\$13
D1555	Removal of fixed space maintainer	\$20
D2000- D2999	III. RESTORATIVE ###	
D2140	Amalgam - one surface, primary or permanent, including polishing	\$28
D2150	Amalgam - two surfaces, primary or permanent, including polishing	\$35
D2160	Amalgam - three surfaces, primary or permanent, including polishing	\$46
D2161	Amalgam - four or more surfaces, primary or permanent, including polishing	\$57
D2330	Resin-based composite - one surface, anterior, including polishing	\$36
D2331	Resin-based composite - two surfaces, anterior, including polishing	\$44
D2332	Resin-based composite - three surfaces, anterior, including polishing	\$58
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior), including polishing	\$66
D2390	Resin-based composite crown, anterior	\$95
D2391	Resin-based composite - one surface, posterior	\$56
D2392	Resin-based composite - two surfaces, posterior	\$75
D2393	Resin-based composite - three surfaces, posterior	\$90
D2394	Resin-based composite - four or more surfaces, posterior	\$95
D2510	Inlay - metallic - one surface**	\$326
D2520	Inlay - metallic - two surfaces**==	\$368
D2530	Inlay - metallic - three or more surfaces**==	\$383
D2542	Onlay - metallic - two surfaces**==	\$383
D2543	Onlay - metallic - three surfaces**==	\$400
D2544	Onlay - metallic - four or more surfaces**==	\$420
D2610	Inlay - porcelain/ceramic - one surface	\$326
D2620	Inlay - porcelain/ceramic - two surfaces	\$368
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$383
D2642	Onlay - porcelain/ceramic - two surfaces	\$383
D2643	Onlay - porcelain/ceramic - three surfaces	\$400
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$420
D2740	Crown - porcelain/ceramic substrate ==	\$450
D2750	Crown - porcelain fused to high noble metal** ==	\$430
D2751	Crown - porcelain fused to predominately base metal ==	\$430
D2752	Crown - porcelain fused to noble metal ==	\$430
D2780	Crown - 3/4 cast high noble metal**==	\$420
D2781	Crown - 3/4 cast predominately base metal ==	\$420
D2782	Crown - 3/4 cast noble metal	\$420
D2783	Crown - 3/4 porcelain/ceramic ==	\$420
D2790	Crown - full cast high noble metal** ==	\$430
D2791	Crown - full cast predominately base metal ==	\$430
D2792	Crown - full cast noble metal ==	\$430
D2794	Crown - titanium ==	\$430
D2910	Recement inlay, onlay, or partial coverage restoration	\$18
D2915	Recement cast or prefabricated post and core	\$18
D2920	Recement crown	\$18

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D2929	Prefabricated porcelain/ceramic crown - primary tooth	\$135
D2930	Prefabricated stainless steel crown - primary tooth	\$110
D2931	Prefabricated stainless steel crown - permanent tooth	\$125
D2932	Prefabricated resin crown	\$135
D2933	Prefabricated stainless steel crown with resin window	\$135
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$145
D2940	Protective restoration	\$30
D2950	Core buildup, including any pins when required	\$113
D2951	Pin retention - per tooth, in addition to restoration	\$24
D2952	Post and core, in addition to crown, indirectly fabricated	\$160
D2953	Each additional indirectly fabricated post - same tooth	\$50
D2954	Prefabricated post and core in addition to crown	\$130
D2957	Each additional prefabricated post - same tooth	\$29
D2960	Labial veneer (resin laminate) - chairside	\$250
D2970	Temporary crown (fractured tooth)	\$100
D2971	Additional procedures to construct new crown under existing partial denture framework	\$125
D2990	Resin infiltration of incipient smooth surface lesions	\$5
D3000- D3999	IV. ENDODONTICS	
D3110	Pulp cap - direct (excluding final restoration)	\$15
D3120	Pulp cap - indirect (excluding final restoration)	\$15
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$50
D3221	Pulpal debridement, primary and permanent teeth	\$50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$50
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$88
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$90
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	\$260
D3320	Endodontic therapy - bicuspid tooth (excluding final restoration)	\$300
D3330	Endodontic therapy - molar (excluding final restoration) ==	\$400
D3331	Treatment of root canal obstruction; non-surgical access	\$0
D3332	Incomplete endodontic therapy: inoperable, unrestorable or fractured tooth	\$150
D3333	Internal root repair of perforation defects	\$120
D3346	Retreatment of previous root canal therapy – anterior	\$315
D3347	Retreatment of previous root canal therapy – bicuspid ==	\$370
D3348	Retreatment of previous root canal therapy – molar ==	\$445
D3410	Apicoectomy - anterior	\$265
D3421	Apicoectomy - bicuspid (first root)	\$300
D3425	Apicoectomy - molar (first root)	\$350
D3426	Apicoectomy - (each additional root)	\$110
D3430	Retrograde filling - per root	\$90
D3950	Canal preparation and fitting of preformed dowel or post	\$20
D4000- D4999	V. PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$188
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$85
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$60
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$275
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or	\$165

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	tooth bounded spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	\$285
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant ==	\$410
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$350
D4268	Surgical revision procedure, per tooth	\$0
D4270	Pedicle soft tissue graft procedure	\$295
D4271	Free soft tissue graft procedure (including donor site surgery)	\$298
D4273	Subepithelial connective tissue graft procedures, per tooth	\$328
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	\$298
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	\$179
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	\$50
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$35
D4910	Periodontal maintenance, for the first two services in any 12-month period+#	\$32
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$25
D4999	Periodontal maintenance, each additional service in same 12-month period+#	\$60
D5000- D5999	VI. PROSTHODONTICS (removable)	
D5110	Complete denture - maxillary ==	\$580
D5120	Complete denture - mandibular ==	\$580
D5130	Immediate denture - maxillary ==	\$620
D5140	Immediate denture - mandibular ==	\$620
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ==	\$580
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ==	\$580
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ==	\$620
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ==	\$620
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$675
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$675
D5410	Adjust complete denture - maxillary	\$27
D5411	Adjust complete denture - mandibular	\$27
D5421	Adjust partial denture - maxillary	\$27
D5422	Adjust partial denture - mandibular	\$27
D5510	Repair broken complete denture base	\$69
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$66
D5610	Repair resin denture base	\$80
D5620	Repair cast framework	\$80
D5630	Repair or replace broken clasp	\$96
D5640	Replace broken teeth - per tooth	\$62
D5650	Add tooth to existing partial denture	\$81
D5660	Add clasp to existing partial denture	\$102
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$223
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$223
D5710	Rebase complete maxillary denture	\$230
D5711	Rebase complete mandibular denture	\$230
D5720	Rebase maxillary partial denture	\$230
D5721	Rebase mandibular partial denture	\$230
D5730	Reline complete maxillary denture (chairside)	\$130

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D5731	Reline complete mandibular denture (chairside)	\$130
D5740	Reline maxillary partial denture (chairside)	\$125
D5741	Reline mandibular partial denture (chairside)	\$125
D5750	Reline complete maxillary denture (laboratory)	\$186
D5751	Reline complete mandibular denture (laboratory)	\$186
D5760	Reline maxillary partial denture (laboratory)	\$186
D5761	Reline mandibular partial denture (laboratory)	\$186
D5820	Interim partial denture (maxillary)	\$190
D5821	Interim partial denture (mandibular)	\$190
D5850	Tissue conditioning, maxillary	\$60
D5851	Tissue conditioning, mandibular	\$60
D5900- D5999	VII. MAXILLOFACIAL PROSTHETICS	
D5931	Obturator prosthesis, surgical #####	\$2,415
D5932	Obturator prosthesis, definitive #####	\$1,687
D5933	Obturator prosthesis, modification #####	\$245
D5936	Obturator prosthesis, interim #####	\$4,023
D6000- D6199	VIII. IMPLANT SERVICES - Not Covered	
D6200- D6999	IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge]) ###	
D6210	Pontic - cast high noble metal**==	\$400
D6211	Pontic - cast predominately base metal ==	\$400
D6212	Pontic - cast noble metal ==	\$400
D6214	Pontic – titanium ==	\$400
D6240	Pontic - porcelain fused to high noble metal**==	\$400
D6241	Pontic - porcelain fused to predominately base metal ==	\$400
D6242	Pontic - porcelain fused to noble metal ==	\$400
D6245	Pontic - porcelain/ceramic ==	\$410
D6600	Inlay - porcelain/ceramic - two surfaces	\$368
D6601	Inlay - porcelain/ceramic - three or more surfaces	\$383
D6602	Inlay - cast high noble metal, two surfaces**	\$368
D6603	Inlay - cast high noble metal, three or more surfaces**	\$383
D6604	Inlay - cast predominantly base metal, two surfaces	\$368
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$383
D6606	Inlay - cast noble metal, two surfaces	\$368
D6607	Inlay - cast noble metal, three or more surfaces	\$383
D6608	Onlay - porcelain/ceramic - two surfaces	\$383
D6609	Onlay - porcelain/ceramic - three or more surfaces	\$400
D6610	Onlay - cast high noble metal, two surfaces**	\$383
D6611	Onlay - cast high noble metal, three or more surfaces**	\$400
D6612	Onlay - cast predominantly base metal, two surfaces	\$383
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$400
D6614	Onlay - cast noble metal, two surfaces	\$383
D6615	Inlay - cast noble metal, three or more surfaces	\$400
D6624	Inlay – titanium	\$368
D6634	Onlay – titanium	\$383
D6740	Crown - porcelain/ceramic ==	\$450
D6750	Crown - porcelain fused to high noble metal**==	\$430
D6751	Crown - porcelain fused to predominately base metal ==	\$430
D6752	Crown - porcelain fused to noble metal ==	\$430
D6780	Crown - 3/4 cast high noble metal**==	\$430
D6781	Crown - 3/4 cast predominately base metal ==	\$430
D6782	Crown - 3/4 cast noble metal ==	\$430
D6783	Crown - 3/4 porcelain/ceramic ==	\$430
D6790	Crown - full cast high noble metal**==	\$430

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D6791	Crown - full cast predominately base metal ==	\$430
D6792	Crown - full cast noble metal ==	\$430
D6794	Crown - titanium	\$430
D6930	Recement fixed partial denture	\$26
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$160
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$130
D6973	Core build up for retainer, including any pins	\$113
D6976	Each additional indirectly fabricated post - same tooth	\$50
D6977	Each additional prefabricated post - same tooth	\$29
D6999	Multiple crown and bridge unit treatment plan - per unit, six or more units per treatment plan ###	\$125
D7000- D7999	X. ORAL AND MAXILLOFACIAL SURGERY	
D7111	Extraction, coronal remnants - deciduous tooth	\$20
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$35
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$110
D7220	Removal of impacted tooth - soft tissue	\$145
D7230	Removal of impacted tooth - partially bony	\$180
D7240	Removal of impacted tooth - completely bony	\$215
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$240
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$110
D7261	Primary closure of a sinus perforation	\$250
D7280	Surgical access of an unerupted tooth	\$250
D7283	Placement of device to facilitate eruption of impacted tooth	\$35
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$125
D7286	Biopsy of oral tissue - soft	\$85
D7288	Brush biopsy - transepithelial sample collection	\$65
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$53
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$26
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$92
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$65
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	\$200
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	\$260
D7471	Removal of lateral exostosis (maxilla or mandible)	\$215
D7472	Removal of torus palatinus	\$215
D7473	Removal of torus mandibularis	\$215
D7510	Incision and drainage of abscess - intraoral soft tissue	\$44
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$48
D7610	Maxilla - open reduction (teeth immobilized, if present) #####	\$1,500
D7620	Maxilla - closed reduction (teeth immobilized, if present) #####	\$1,100
D7630	Mandible - open reduction (teeth immobilized, if present) #####	\$5,000
D7640	Mandible - closed reduction (teeth immobilized, if present) #####	\$2,200
D7955	Repair of maxillofacial soft and/or hard tissue defect #####	\$1,500
D7960	Frenulectomy - also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	\$100
D7963	Frenuloplasty	\$168
D9000- D9999	XII. ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$25

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D9120	Fixed partial denture sectioning	\$30
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$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
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$34
D9420	Hospital or ambulatory surgical center call #####	\$250
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$10
D9440	Office visit - after regularly scheduled hours	\$50
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9951	Occlusal adjustment - limited	\$23
D9971	Odontoplasty - 1 to 2 teeth; includes removal of enamel projections	\$23
D9972	External bleaching - per arch – performed in office	\$165
D9975	External bleaching for home application, per arch; includes material and fabrication of custom trays	\$99

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

+ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206, D1208, 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.

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 surgical services.

Procedure Code is classified as a Pediatric Essential Benefit and applies to members under age 19 and will not exceed the Maximum Out Of Pocket of \$350.

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== Procedure code is classified as a Pediatric Essential Benefit and the Patient Charge for Members under age 19 will not exceed the Maximum Out of Pocket of \$350. There is no Maximum Out of Pocket for Members age 19 or over and the Member is responsible for the Patient Charge listed.

Plan schedule U10TXI03 is only valid for Covered Services rendered by Participating Dentists in the State of Texas.

CDT Code++	Covered Services and Patient Charges	Patient Charges
D8000-D8999	XI. ORTHODONTICS**	
D8070	Comprehensive orthodontic treatment of the transitional dentition ==	\$2,500
D8080	Comprehensive orthodontic treatment of the adolescent dentition ==	Child:\$2,500
D8090	Comprehensive orthodontic treatment of the adult dentition ==	Adult: \$2,800
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	\$250
D8670	Periodic orthodontic treatment visit	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers) ==	\$400
D8999	Consultation to determine that orthodontic treatment will begin (includes treatment plan, records and evaluation	\$250

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

** Child orthodontics applies to a Member under age 19; adult orthodontics applies to a Member age 19 and above. A Member's age is determined on the date of banding.

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

== The Copayment limit per Member under age 19 is \$350 per calendar year when services are medically necessary as defined by your state's benchmark. Members age 19 and over are subject to the Copayment shown.

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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 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 Specialty Dentist.

Limited orthodontic treatment and Interceptive (Phase 1) 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 Specialists 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 lingual 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.

IMPORTANT NOTICE REGARDING LANGUAGE ASSISTANCE & DISCRIMINATION
AVISO IMPORTANTE SOBRE LA ASISTENCIA DE IDIOMA Y DISCRIMINACIÓN

<p>English</p>	<p>If you or the person you are helping has questions about your insurance benefits, claims, or coverage, you have the right to get help and information in your language at no cost. To talk to an interpreter: if you have insurance from your employer, call the telephone number on your identification card; for all other members, please call 844-561-5600.</p> <p>The Guardian and its subsidiaries* comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</p>
<p>Spanish Español</p>	<p>Si usted o la persona que está ayudando tiene preguntas acerca de su seguro, las reclamaciones o cobertura, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete: si tiene seguro de su empleador, llame al número de teléfono que aparece en su tarjeta de identificación; para todos los demás miembros, por favor llame al 844-561-5600.</p> <p>The Guardian y sus subsidiarias * cumplir con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.</p>
<p>Chinese 中文</p>	<p>如果你或你正在帮助的人拥有你的保险利益、索赔或覆盖的问题，你有没有成本，以获取帮助和信息在你的语言的权利。要交的解释：如果您从您的雇主有保险，打电话给你的身份证上的电话号码；所有其他成员，请致电 844-561-5600。</p> <p>卫报及其子公司*遵守适用的联邦民权法和种族，肤色，国籍，年龄，残疾，或性的基础上不歧视。</p>
<p>Vietnamese Tiếng Việt</p>	<p>Nếu bạn hoặc người bạn đang giúp đỡ có câu hỏi về quyền lợi bảo hiểm, yêu cầu của bạn, hoặc bảo hiểm, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn miễn phí. Để nói chuyện với một thông dịch viên: nếu bạn có bảo hiểm từ công ty của bạn, hãy gọi số điện thoại trên thẻ nhận dạng của bạn; cho tất cả các thành viên khác, xin vui lòng gọi 844-561-5600.</p> <p>The Guardian và các công ty con của nó * tuân thủ pháp luật quyền dân sự liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, hoặc quan hệ tình dục.</p>
<p>Korean 한국어</p>	<p>당신이나 당신이 도움이 되고 사람이 당신의 보험 혜택, 청구, 또는 범위에 대한 질문이 있는 경우, 당신은 무료로 귀하의 언어로 도움과 정보를 얻을 수 있는 권리가 있습니다. 통역 얘기하려면, 당신은 당신의 고용주로부터 보험이 있는 경우, 귀하의 ID 카드에 전화 번호로 전화; 다른 모든 구성원에 대해, 844-561-5600로 전화 해주십시오.</p> <p>가디언과 그 자회사는 해당 연방 민권법을 준수하고 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 근거하여 차별하지 않습니다*.</p>
<p>Tagalog Tagalog</p>	<p>Kung ikaw o ang taong ikaw ay pagtulong ay may mga katanungan tungkol sa inyong mga benepisyo sa insurance, claims, o coverage, ikaw ay may karapatan upang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang interpreter: kung mayroon kang insurance mula sa iyong tagapag-empleyo, tawagan ang numero ng telepono sa iyong identification card; para sa lahat ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600.</p> <p>The Guardian at ang mga subsidiaries * sumusunod sa naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaaring makita ang kaibhan sa batayan ng lahi, kulay, bansang pinagmulan, edad, kapansanan, o sex.</p>
<p>Russian Русский</p>	<p>Если вы или человек, которому вы помогаете есть вопросы по поводу вашего страховых выплат, претензий, или покрытия, вы имеете право получить помощь и информацию на вашем языке без каких-либо затрат. Для того, чтобы поговорить с переводчиком: если у вас есть страхование от Вашего работодателя, позвоните по номеру телефона на вашей идентификационной карточке; для всех остальных членов, просьба звонить по телефону 844-561-5600.</p> <p>The Guardian и его дочерние компании * соответствии с действующими федеральными законами о гражданских правах и не допускать дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.</p>
<p>Arabic العربية</p>	<p>إذا كنت أنت أو الشخص الذي يساعد فيه أسئلة حول فوائد التأمين والمطالبات، أو تغطية، لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. التحدث إلى مترجم: إذا كان لديك التأمين من صاحب العمل الخاص بك، الاتصال على رقم الهاتف على بطاقة الهوية الخاصة بك. لجميع الأعضاء، يرجى الاتصال 844-561-5600.</p> <p>الجاردريان والشركات التابعة لها * الالتزام بالفوانين الاتحادية المطبقة الحقوق المدنية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة، أو الجنس..</p>
<p>French Creole-Haitian Creole Kreyòl Ayisyen</p>	<p>Si ou menm oswa moun nan w ap ede gen kesyon sou benefis asirans ou, reklamasyon, oswa pwoteksyon, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou a pa koute. Pou pale ak yon entèprèt: si ou gen asirans nan men anplwayè ou, rele nimewo telefòn sou kat idantifikasyon ou; pou tout lòt manm, tanpri rele 844-561-5600.</p> <p>The Guardian ak filiales li yo * konfòme yo avèk lwa sou dwa sivil Federal aplikab yo, epi pa fè diskriminasyon sou baz ras, koulè, orijin nasyonal, laj, andikap, oswa fè sèks.</p>
<p>Polish Polskie</p>	<p>Jeśli Ty lub osoba, do której pomoc ma pytania dotyczące świadczeń z ubezpieczenia, roszczenia lub pokrycia, masz prawo do uzyskania pomocy i informacji w swoim języku, bez żadnych kosztów. Aby rozmawiać z tłumaczem: jeśli masz ubezpieczenie od pracodawcy, należy zadzwonić pod numer telefonu na karcie identyfikacyjnej; dla wszystkich pozostałych członków, zadzwoń 844-561-5600.</p> <p>The Guardian i jej spółek zależnych * przestrzegania obowiązujących przepisów federalnych praw obywatelskich i nie dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność, czy płeć.</p>

<p>French Français</p>	<p>Si vous ou la personne que vous aidez a des questions sur vos prestations d'assurance, les prétentions ou la couverture, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue, sans frais. Pour parler à un interprète: si vous avez l'assurance de votre employeur, appelez le numéro de téléphone sur votre carte d'identité; pour tous les autres membres, s'il vous plaît appelez 844-561-5600.</p> <p>The Guardian et ses filiales * sont conformes aux lois fédérales relatives aux droits civils applicables et ne fait pas de discrimination sur la base de la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe.</p>
<p>Italian Italiano</p>	<p>Se voi o la persona che state aiutando ha domande circa la vostra prestazioni assicurative, reclami, o la copertura, si ha il diritto di richiedere assistenza e informazioni nella propria lingua, senza alcun costo. Per parlare con un interprete: se avete l'assicurazione dal datore di lavoro, chiamare il numero di telefono sulla carta d'identità; per tutti gli altri membri, si prega di chiamare 844-561-5600.</p> <p>The Guardian e le sue controllate * conformi alle leggi federali vigenti diritti civili e non discrimina sulla base di razza, colore, nazionalità, età, disabilità, o di sesso.</p>
<p>Persian-Farsi فارسی-فارسی</p>	<p>اگر شما یا شخصی که شما در حال کمک به سوالات در مورد مزایای بیمه خود را، ادعا می کنید، و یا پوشش، شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشید. برای صحبت با یک مترجم: اگر بیمه از کارفرمای خود، تماس با شماره تلفن بر روی کارت شناسایی خود را. برای همه اعضای دیگر، لطفاً 844-561-5600 تماس بگیرید..</p> <p>گاردین و شرکتهای تابعه آن * * * * مطابق با قوانین فدرال حقوق مدنی قابل اجرا می کند و بر اساس نژاد، رنگ پوست، ملیت، سن، معلولیت و یا رابطه جنسی قائل نمی شود.</p>
<p>Armenian Հայերեն</p>	<p>Եթե դուք կամ այն անձը, դուք օգնում ունի հարցեր ձեր ապահովագրական հատուցումներից, պահանջների, կամ լուսաբանման, դուք իրավունք ունեք ստանալու օգնություն եւ տեղեկատվություն Ձեր լեզվով ոչ մի գնով: Խոսել է թարգմանչի: Եթե ունեք ապահովագրություն Ձեր գործատուի, զանգահարեք հեռախոսահամարը Ձեր նույնականացման քարտ. բոլոր մյուս անդամների համար, խնդրում ենք զանգահարել 844-561-5600.</p> <p>The Guardian եւ իր դուստր ձեռնարկություններն * համապատասխան են կիրառելի դաշնային քաղաքացիական իրավունքների օրենքների եւ չի խտրականություն հիման վրա ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, հաշմանդամության, կամ սեռից:</p>
<p>German Deutsche</p>	<p>Wenn Sie oder die Person, die Sie helfen, Fragen zu Ihrem Versicherungsleistungen , Ansprüche oder Abdeckung, haben Sie das Recht auf kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um auf einen Dolmetscher sprechen: Wenn Sie eine Versicherung von Ihrem Arbeitgeber haben, rufen Sie die Telefonnummer auf der Ausweiskarte ; für alle anderen Mitglieder, rufen Sie bitte 844-561-5600.</p> <p>The Guardian und ihre Tochtergesellschaften * mit den geltenden Bundes Bürgerrechte Gesetze einhalten und nicht zu diskriminieren auf der Grundlage von Rasse, Hautfarbe , nationaler Herkunft, Alter, Behinderung oder Geschlecht.</p>
<p>Portuguese Português</p>	<p>Se você ou a pessoa que você está ajudando tem dúvidas sobre seus benefícios de seguro, reivindicações, ou cobertura, você tem o direito de obter ajuda e informações na sua língua, sem nenhum custo. Para falar com um intérprete: se você tem seguro de seu empregador, ligue para o número de telefone no seu cartão de identificação; para todos os outros membros, ligue para 844-561-5600.</p> <p>Este aviso tem informações importantes sobre a sua aplicação ou sua cobertura de seguro. Olhe para as datas-chave neste</p> <p>The Guardian e suas subsidiárias * cumprir com as leis federais aplicáveis direitos civis e não discriminar com base em raça, cor, nacionalidade, idade, deficiência ou sexo.</p>

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