

**Guardian’s DHMO Plan**

The Guardian DentalGuard DHMO plans allow you to choose to receive care from any participating licensed dentist in the network, and pay a set co-pay for your office visit. Under this plan, you must choose a primary care dentist. All of your dental care will be provided by, or arranged by, your primary care dentist.

Under the Affordable Care Act (ACA), insurers must provide coverage for 10 essential health benefits (EHBs). This plan includes the pediatric essential health benefit, which is a comprehensive set of dental services for children under 19. These services are covered without annual or lifetime limits as long as you receive care-in-network. Also included is coverage for medically necessary orthodontics.

<b>Managed DentalGuard Family Plan—For Plan Years Beginning in 2016</b>		
	In-Network	Out-of-Network
<b>You Pay (Average cost is illustrated below. Refer to detailed list on the following pages.)</b>		
<b>Diagnosis &amp; Preventive Care</b> *Exams, cleaning, x-rays	\$0	Not Covered
<b>Basic Services</b> *Fillings, simple tooth extractions	\$69	Not Covered
<b>Major Services</b> *Crowns, inlays, onlays, and cast restorations	\$346	Not Covered
<b>Standard Orthodontic Coverage</b> (without verification of medical necessity) D8080 *Comprehensive Orthodontic Treatment of the Adolescent	\$2,500	Not Covered
<b>Standard Orthodontic Coverage</b> (without verification of medical necessity) D8090 *Comprehensive Orthodontic Treatment of the Adult	\$2,800	Not Covered
<b>Office Visit</b>	\$15	Not Covered
<b>Out of Pocket Maximum (Individual / Family) – Applies to child essential health benefits only</b>	\$350 / \$700	Not Covered
<b>Annual Maximum</b>	None	N/A

\*Current Dental Terminology © 2013 American Dental Association (ADA). All rights reserved. Note: Procedures listed above under Preventive, Basic, Major and Orthodontics are for sample purposes only and do not encompass all covered services. For a list of co-payments for all covered services, please see the Covered Dental Services And Patient Charges on the following pages, and your policy contract for details. Limitations and exclusions apply. Plan documents are the final arbiter of coverage. GP-I-MDG-NY-FP-ON-15

**Plan designs are not available in the following counties:** Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saint Lawrence, Saratoga, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates



**Covered Dental Services and Patient Charges – U10NYI02**

The services covered by this Policy 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 Primary Care Dentist.

The Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of this Policy, 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 New York. 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 Policy, and (2) rendered by Participating Dentists in the State of New York.

Schedule of Benefits		
CDT Codes		Plan Schedules - Copayments
<b>D0100-D0999</b>	<b>I. DIAGNOSTIC</b>	
<b>D0120</b>	Periodic oral evaluation - established patient	\$0
<b>D0140</b>	Limited oral evaluation - problem focused	0
<b>D0145</b>	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
<b>D0150</b>	Comprehensive oral evaluation - new or established patient	0
<b>D0170</b>	Re-evaluation - limited problem focused (established patient; not post-operative visit)	0
<b>D0180</b>	Comprehensive periodontal evaluation - new or established patient	0
<b>D0210</b>	Intraoral radiographs - complete series of radiographic images	0
<b>D0220</b>	Intraoral - periapical first radiographic image	0
<b>D0230</b>	Intraoral - periapical each additional radiographic image	0
<b>D0240</b>	Intraoral - occlusal radiographic image	0
<b>D0270</b>	Bitewing - single radiographic image	0
<b>D0272</b>	Bitewings - two radiographic images	0
<b>D0273</b>	Bitewings - three radiographic images	0
<b>D0274</b>	Bitewings - four radiographic images	0
<b>D0277</b>	Vertical bitewings - 7 to 8 radiographic images	0
<b>D0320</b>	Temporomandibular joint arthrogram, including injection	0
<b>D0321</b>	Other temporomandibular joint radiographic images, by report	0
<b>D0322</b>	Tomographic survey <sup>^^^</sup>	0
<b>D0330</b>	Panoramic radiographic image	0
<b>D0368</b>	Cone beam CT capture and interpretation for TMJ series including two or more exposures	0
<b>D0384</b>	Cone beam CT image capture for TMJ series including two or more exposures	0
<b>D0431</b>	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50
<b>D0460</b>	Pulp vitality tests	0
<b>D0470</b>	Diagnostic casts	0
<b>D0999</b>	Office visit during regular hours, general dentist only	15
<b>D1000-D1999</b>	<b>II. PREVENTIVE</b>	
<b>D1110</b>	Prophylaxis - adult, for the first two services in any 12-month period	\$0
<b>D1120</b>	Prophylaxis - child, for the first two services in any 12-month period	0
<b>D1999</b>	Prophylaxis - adult or child, for each additional service in same 12-month period	60
<b>D1203</b>	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	0
<b>D1204</b>	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period	0
<b>D1206</b>	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12-month period	12
<b>D1208</b>	Topical application of fluoride, for the first two services in any 12-month period	0
<b>D2999</b>	Topical fluoride (adult or child), each additional service in the same 12-month period	20
<b>D1310</b>	Nutritional counseling for control of dental diseases	0
<b>D1330</b>	Oral hygiene instructions	0
<b>D1351</b>	Sealant - per tooth (molars)	14
<b>D9999</b>	Sealant - per tooth (non-molars)	35
<b>D1352</b>	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	14



**Schedule of Benefits**

CDT Codes		Plan Schedules - Copayments
<b>D1000-D1999</b>	<b>II. PREVENTIVE – cont.</b>	
<b>D1510</b>	Space maintainer - fixed – unilateral	\$75
<b>D1515</b>	Space maintainer - fixed – bilateral	110
<b>D1525</b>	Space maintainer - removable – bilateral	110
<b>D1550</b>	Re-cementation of space maintainer	13
<b>D1555</b>	Removal of fixed space maintainer	20
<b>D2000-D2999</b>	<b>III. RESTORATIVE</b>	
	<b>Crowns - single restorations only</b>	
<b>D2140</b>	Amalgam - one surface, primary or permanent	\$28
<b>D2150</b>	Amalgam - two surfaces, primary or permanent	39
<b>D2160</b>	Amalgam - three surfaces, primary or permanent	46
<b>D2161</b>	Amalgam - four or more surfaces, primary or permanent	57
<b>D2330</b>	Resin-based composite - one surface, anterior	36
<b>D2331</b>	Resin-based composite - two surfaces, anterior	44
<b>D2332</b>	Resin-based composite - three surfaces, anterior	58
<b>D2335</b>	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	66
<b>D2390</b>	Resin-based composite crown, anterior	95
<b>D2391</b>	Resin-based composite - one surface, posterior	56
<b>D2392</b>	Resin-based composite - two surfaces, posterior	75
<b>D2393</b>	Resin-based composite - three surfaces, posterior	90
<b>D2394</b>	Resin-based composite - four or more surfaces, posterior	95
<b>D2510</b>	Inlay - metallic - one surface	326
<b>D2520</b>	Inlay - metallic - two surfaces	368
<b>D2530</b>	Inlay - metallic - three or more surfaces	383
<b>D2542</b>	Onlay - metallic - two surfaces	383
<b>D2543</b>	Onlay - metallic - three surfaces	400
<b>D2544</b>	Onlay - metallic - four or surfaces	420
<b>D2610</b>	Inlay - porcelain/ceramic - one surface	326
<b>D2620</b>	Inlay - porcelain/ceramic - two surfaces	368
<b>D2630</b>	Inlay - porcelain/ceramic - three or more surfaces	383
<b>D2642</b>	Onlay - porcelain/ceramic - two surfaces	383
<b>D2643</b>	Onlay - porcelain/ceramic - three surfaces	400
<b>D2644</b>	Onlay - porcelain/ceramic - four or more surfaces	420
<b>D2740</b>	Crown - porcelain/ceramic substrate	450
<b>D2750</b>	Crown - porcelain fused to high noble metal	430
<b>D2751</b>	Crown - porcelain fused to predominately base metal	430
<b>D2752</b>	Crown - porcelain fused to noble metal	430
<b>D2780</b>	Crown - 3/4 cast high noble metal	420
<b>D2781</b>	Crown - 3/4 cast predominately base metal	420
<b>D2782</b>	Crown - 3/4 cast noble metal	420
<b>D2783</b>	Crown - 3/4 porcelain/ceramic	420
<b>D2790</b>	Crown - full cast high noble metal	430
<b>D2791</b>	Crown - full cast predominately base metal	430
<b>D2792</b>	Crown - full cast noble metal	430
<b>D2794</b>	Crown - titanium	430
<b>D2910</b>	Recement inlay, onlay, or partial coverage restoration	18
<b>D2915</b>	Recement cast or prefabricated post and core	18
<b>D2920</b>	Recement crown	18
<b>D2929</b>	Prefabricated porcelain/ceramic crown - primary tooth	135
<b>D2930</b>	Prefabricated stainless steel crown - primary tooth	110
<b>D2931</b>	Prefabricated stainless steel crown - permanent tooth	125
<b>D2932</b>	Prefabricated resin crown	135
<b>D2933</b>	Prefabricated stainless steel crown with resin window	135
<b>D2934</b>	Prefabricated esthetic coated stainless steel crown - primary tooth	145
<b>D2940</b>	Protective restoration	30
<b>D2950</b>	Core buildup, including any pins when required	113
<b>D2951</b>	Pin retention - per tooth, in addition to restoration	24
<b>D2952</b>	Post and core, in addition to crown, indirectly fabricated	160



**Schedule of Benefits**

CDT Codes		Plan Schedules - Copayments
<b>D2000-D2999</b>	<b>III. RESTORATIVE – cont.</b>	
<b>D2953</b>	Each additional indirectly fabricated post - same tooth	50
<b>D2954</b>	Prefabricated post and core in addition to crown	130
<b>D2957</b>	Each additional prefabricated post - same tooth	29
<b>D2960</b>	Labial veneer (resin laminate) – chairside	250
<b>D2970</b>	Temporary crown (fractured tooth)	100
<b>D2971</b>	Additional procedures to construct new crown under existing partial denture framework	125
<b>D2990</b>	Resin infiltration of incipient smooth surface lesions	5
<b>D3000-D3999</b>	<b>IV. ENDODONTICS</b>	
<b>D3110</b>	Pulp cap - direct (excluding final restoration)	\$15
<b>D3120</b>	Pulp cap - indirect (excluding final restoration)	15
<b>D3220</b>	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	50
<b>D3221</b>	Pulpal debridement, primary and permanent teeth	50
<b>D3222</b>	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50
<b>D3230</b>	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	88
<b>D3240</b>	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	90
<b>D3310</b>	Endodontic therapy - anterior tooth (excluding final restoration)	260
<b>D3320</b>	Endodontic therapy - bicuspid tooth (excluding final restoration)	300
<b>D3330</b>	Endodontic therapy - molar (excluding final restoration)	400
<b>D3331</b>	Treatment of root canal obstruction; non-surgical access	0
<b>D3332</b>	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	150
<b>D3333</b>	Internal root repair of perforation defects	120
<b>D3346</b>	Retreatment of previous root canal therapy – anterior	315
<b>D3347</b>	Retreatment of previous root canal therapy - bicuspid	370
<b>D3348</b>	Retreatment of previous root canal therapy – molar	445
<b>D3410</b>	Apicoectomy – anterior	265
<b>D3421</b>	Apicoectomy - bicuspid (first root)	300
<b>D3425</b>	Apicoectomy - molar (first root)	350
<b>D3426</b>	Apicoectomy (each additional root)	110
<b>D3430</b>	Retrograde filling - per root	90
<b>D3950</b>	Canal preparation and fitting of preformed dowel or post	20
<b>D4000-D4999</b>	<b>V. PERIODONTICS</b>	
<b>D4210</b>	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$188
<b>D4211</b>	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	85
<b>D4212</b>	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	60
<b>D4240</b>	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	275
<b>D4241</b>	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	165
<b>D4249</b>	Clinical crown lengthening - hard tissue	285
<b>D4260</b>	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	410
<b>D4261</b>	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	350
<b>D4268</b>	Surgical revision procedure, per tooth	0
<b>D4270</b>	Pedicle soft tissue graft procedure	295
<b>D4271</b>	Free soft tissue graft procedure (including donor site surgery)	298
<b>D4273</b>	Subepithelial connective tissue graft procedures, per tooth	328
<b>D4277</b>	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft	298
<b>D4278</b>	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in a graft	179
<b>D4341</b>	Periodontal scaling and root planing, four or more teeth per quadrant	50
<b>D4342</b>	Periodontal scaling and root planing, one to three teeth per quadrant	30
<b>D4355</b>	Full mouth debridement to enable comprehensive evaluation and diagnosis	35
<b>D4910</b>	Periodontal maintenance, for the first two services in any 12-month period+	32
<b>D4920</b>	Unscheduled dressing change (by someone other than treating dentist or their staff)	25
<b>D4999</b>	Periodontal maintenance, each additional service in same 12-month period	60
<b>D5000-D5999</b>	<b>VI. PROSTHODONTICS (removable)</b>	
<b>D5110</b>	Complete denture - maxillary	\$580
<b>D5120</b>	Complete denture - mandibular	580
<b>D5130</b>	Immediate denture - maxillary	620
<b>D5140</b>	Immediate denture - mandibular	620



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**Schedule of Benefits**

CDT Codes		Plan Schedules - Copayments
D5000-D5999	<b>VI. PROSTHODONTICS (removable) – cont.</b>	
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
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	<b>VII. MAXILLOFACIAL PROSTHETICS - Not Covered</b>	
D6000-D6199	<b>VIII. IMPLANT SERVICES - Not Covered</b>	
D6200-D6999	<b>IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge])</b>	
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



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CDT Codes		Plan Schedules - Copayments
<b>D6200-D6999</b>	<b>IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge]) – cont.</b>	
<b>D6610</b>	Onlay - cast high noble metal, two surfaces	383
<b>D6611</b>	Onlay - cast high noble metal, three or more surfaces	400
<b>D6612</b>	Onlay - cast predominantly base metal, two surfaces	383
<b>D6613</b>	Onlay - cast predominantly base metal, three or more surfaces	400
<b>D6614</b>	Onlay - cast noble metal, two surfaces	383
<b>D6615</b>	Inlay - cast noble metal, three or more surfaces	400
<b>D6624</b>	Inlay – titanium	368
<b>D6634</b>	Onlay – titanium	383
<b>D6740</b>	Crown - porcelain/ceramic	450
<b>D6750</b>	Crown - porcelain fused to high noble metal	430
<b>D6751</b>	Crown - porcelain fused to predominately base metal	430
<b>D6752</b>	Crown - porcelain fused to noble metal	430
<b>D6780</b>	Crown - 3/4 cast high noble metal	430
<b>D6781</b>	Crown - 3/4 cast predominately base metal	430
<b>D6782</b>	Crown - 3/4 cast noble metal	430
<b>D6783</b>	Crown - 3/4 porcelain/ceramic	430
<b>D6790</b>	Crown - full cast high noble metal	430
<b>D6791</b>	Crown - full cast predominately base metal	430
<b>D6792</b>	Crown - full cast noble metal	430
<b>D6794</b>	Crown - titanium	430
<b>D6930</b>	Recement fixed partial denture	26
<b>D6970</b>	Post and core in addition to fixed partial denture retainer, indirectly fabricated	160
<b>D6972</b>	Prefabricated post and core in addition to fixed partial denture retainer	130
<b>D6973</b>	Core build up for retainer, including any pins	113
<b>D6976</b>	Each additional cast post - same tooth	50
<b>D6977</b>	Each additional prefabricated post - same tooth	29
<b>D6999</b>	Multiple crown and bridge unit treatment plan - per unit, six or more units per treatment plan	125
<b>D7000-D7999</b>	<b>X. ORAL AND MAXILLOFACIAL SURGERY</b>	
<b>D7111</b>	Extraction, coronal remnants - deciduous tooth	\$20
<b>D7140</b>	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	35
<b>D7210</b>	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	110
<b>D7220</b>	Removal of impacted tooth - soft tissue	145
<b>D7230</b>	Removal of impacted tooth - partially bony	180
<b>D7240</b>	Removal of impacted tooth - completely bony	215
<b>D7241</b>	Removal of impacted tooth - completely bony, with unusual surgical complications	240
<b>D7250</b>	Surgical removal of residual tooth roots (cutting procedure)	110
<b>D7261</b>	Primary closure of a sinus perforation	250
<b>D7280</b>	Surgical access of an unerupted tooth	250
<b>D7283</b>	Placement of device to facilitate eruption of impacted tooth	35
<b>D7285</b>	Biopsy of oral tissue - hard (bone, tooth)	125
<b>D7286</b>	Biopsy of oral tissue - soft	85
<b>D7288</b>	Brush biopsy - transepithelial sample collection	65
<b>D7310</b>	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	53
<b>D7311</b>	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	26
<b>D7320</b>	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	92
<b>D7321</b>	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	65
<b>D7450</b>	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	200
<b>D7451</b>	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	260
<b>D7471</b>	Removal of lateral exostosis (maxilla or mandible)	215
<b>D7472</b>	Removal of torus palatines	215
<b>D7473</b>	Removal of torus mandibularis	215
<b>D7510</b>	Incision and drainage of abscess - intraoral soft tissue	44
<b>D7511</b>	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	48
<b>D7610</b>	Maxilla - open reduction (teeth immobilized, if present)	1,500
<b>D7620</b>	Maxilla - closed reduction (teeth immobilized, if present)	1,100



**Schedule of Benefits**

CDT Codes		Plan Schedules - Copayments
<b>D7000-D7999</b>	<b>X. ORAL AND MAXILLOFACIAL SURGERY – cont.</b>	
<b>D7630</b>	Mandible - open reduction (teeth immobilized, if present)	\$5,000
<b>D7640</b>	Mandible - closed reduction (teeth immobilized, if present)	2,200
<b>D7810</b>	Open reduction of dislocation	1,800
<b>D7820</b>	Closed reduction of dislocation	1,600
<b>D7830</b>	Manipulation under anesthesia	1,600
<b>D7955</b>	Repair of maxillofacial soft and/or hard tissue defect	1,500
<b>D7960</b>	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	100
<b>D7963</b>	Frenuloplasty	168
<b>D9000-D9999</b>	<b>XII. ADJUNCTIVE GENERAL SERVICES</b>	
<b>D9110</b>	Palliative (emergency) treatment of dental pain - minor procedure	\$25
<b>D9120</b>	Fixed partial denture sectioning	30
<b>D9215</b>	Local anesthesia in conjunction with operative or surgical procedures	0
<b>D9220</b>	Deep sedation/general anesthesia - first 30 minutes	195
<b>D9221</b>	Deep sedation/general anesthesia - each additional 15 minutes	75
<b>D9241</b>	Intravenous conscious sedation/analgesia - first 30 minutes	195
<b>D9242</b>	Intravenous conscious sedation/analgesia - each additional 15 minutes	75
<b>D9248</b>	Non-intravenous conscious sedation	125
<b>D9310</b>	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	34
<b>D9420</b>	Hospital or ambulatory surgical center call	250
<b>D9430</b>	Office visit for observation (during regularly scheduled hours) - no other services performed	10
<b>D9440</b>	Office visit - after regularly scheduled hours	50
<b>D9450</b>	Case presentation, detailed and extensive treatment planning	0
<b>D9940</b>	Occlusal guard, by report	85
<b>D9951</b>	Occlusal adjustment – limited	23
<b>D9971</b>	Odontoplasty - 1 - 2 teeth; includes removal of enamel projections	23
<b>D9972</b>	External bleaching - per arch - performed in office	165
<b>D9975</b>	External bleaching for home application, per arch; includes material and fabrication of custom trays.	99
	Broken appointment	25

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

Routine cleaning (prophylaxis: D1110, D1120, D19999) 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.

Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12 month intervals  
Fluoride treatment (D1203, D1204, D1206 D1208 and D2999) - four (4) in any twelve (12) month period.

Sealants - limited to permanent teeth, up to the 19th birthday - one (1) per tooth in any three (3) year period.

Plan Schedule is only valid for Covered Services rendered by Participating Dentists in the State of New York.

Underwritten by: First Commonwealth Insurance Company - (IL), First Commonwealth of Missouri - (MO), First Commonwealth Limited Health Services Corporation - (IN), First Commonwealth Limited Health Services Corporation of Michigan - (MI), Managed Dental Care - (CA), Managed DentalGuard, Inc. - (NJ, OH, TX), The Guardian Life Insurance Company of America - (CO, FL, NY and all PPO and Indemnity plans). All referenced companies are wholly owned subsidiaries of The Guardian Life Insurance Company of America, New York, NY.



Covered Services and Patient Charges		
CDT Codes++		Plan Schedules - Patient Charges
D8000-D8999	<b>XI. ORTHODONTICS</b>	
D8050	Interceptive orthodontic treatment of the primary dentition	\$1,000
D8060	Interceptive orthodontic treatment of the transitional dentition	1,000
D8070	Comprehensive orthodontic treatment of the transitional dentition	2,500
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2,500
D8090	Comprehensive orthodontic treatment of the adult dentition	2,800
D8210	Removable appliance therapy	252
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

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

Child orthodontics is limited to dependent children under age 19.

Plan schedule NYOE is only valid for Covered Services rendered by Participating Dentists in the State of New York.

**The Plan Covers:**

We cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as; cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

Rapid Palatal Expansion (RPE)

Placement of component parts (e.g. brackets, bands);

Interceptive orthodontic treatment;

Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);

Removable appliance therapy; and

Orthodontic retention (removal of appliances, construction and placement of retainers)

**This Plan Does Not Cover:**

Medically Necessary: In general, We will not cover any health care service, procedure, treatment, or device that We determine is not Medically Necessary. If an external Appeal Agent certified by the State overturns Our denial, however, We will Cover the procedure, treatment, or service, for which Coverage has been denied, to the extent that such procedure, treatment or service, is other wise Covered under the terms of the Certificate.





## Exclusions and Limitations

No coverage is available under this Certificate for the following:

- A. Aviation.** - We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- B. Convalescent and Custodial Care.** - We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
- C. Cosmetic Services.** - We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.
- D. Coverage Outside of the United States, Canada or Mexico.** - We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in the Pediatric Dental Care section of this Certificate.
- E. Experimental or Investigational Treatment.** - We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.
- F. Felony Participation.** - We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.
- G. Foot Care.** - We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- H. Government Facility.** - We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.
- I. Medical Services.** - We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.
- J. Medically Necessary.** - In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.
- K. Medicare or Other Governmental Program.** - We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).
- L. Military Service.** - We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- M. No-Fault Automobile Insurance.** - We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.
- N. Pre-Existing Conditions.** - For a period of 12 months from the enrollment date, We do not Cover any conditions for which medical advice was given, treatment was recommended by or received from a physician within six (6) months before the effective date of Your coverage. We will not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information. The pre-existing condition exclusion does not apply to the pediatric dental essential health benefit.
- O. Services Not Listed.** - We do not Cover services that are not listed in this Certificate as being Covered.
- P. Services Provided by a Family Member.** - We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.
- Q. Services Separately Billed by Hospital Employees.** - We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
- R. Services with No Charge.** - We do not Cover services for which no charge is normally made.
- S. Vision Services.** - We do not Cover the examination or fitting of eyeglasses or contact lenses.
- T. War.** - We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.
- U. Workers' Compensation.** - We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.



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