GUARDIAN ® DENTAL COVERAGE FOR INDIVIDUALS AND FAMILIES ON THE HEALTH INSURANCE EXCHANGE FOR NEW YORK

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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, including diagnostic and preventive benefits such as oral examinations, x-rays, topical fluoride, and dental sealants, restorative services such as fillings, as well as coverage for major services such as oral surgery and crowns. 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.

Managed DentalGuard Child Essentials—For Plan Years Beginning in 2016		
	In-Network	Out-of-Network
You Pay (Average cost is illustrated below. Refer to detailed list on the following pages.)		
Diagnosis & Preventive Care *Exams, cleaning, x-rays	$4	Not Covered
Basic Services *Fillings, simple tooth extractions	$81	Not Covered
Major Services *Crowns, inlays, onlays, and cast restorations	$279	Not Covered
Standard Orthodontic Coverage (without verification of medical necessity) D8080 *Comprehensive Orthodontic Treatment of the Adolescent	$2,500	Not Covered
Standard Orthodontic Coverage (without verification of medical necessity) D8090 *Comprehensive Orthodontic Treatment of the Adult	$2,800	Not Covered
Office Visit	$15	Not Covered
Out of Pocket Maximum (Individual / Family) – Applies to child essential health benefits only)	$350 / $700	Not Covered
Annual Maximum	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. Form IP-MDG-NY-EHB-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

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Covered Dental Services and Patient Charges – ENYI02

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		Copayments
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
D0320	Temporomandibular joint arthrogram, including injection	0
D0321	Other temporomandibular joint radiographic images, by report	0
D0322	Tomographic survey	0
D0330	Panoramic radiographic image	0
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	0
D0384	Cone beam CT image capture for TMJ series including two or more exposures	0
D0460	Pulp vitality tests	0
D0999	Office visit during regular hours, general dentist only	15
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	0
D1203	Topical application of fluoride (prophylaxis not included) - child	0
D1204	Topical application of fluoride (prophylaxis not included) - adult	0
D1206	Topical application of fluoride varnish	12
D1208	Topical application of fluoride	0
D1351	Sealant - per tooth	14
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
D2000-D2999	**III. RESTORATIVE**	
D2140	Amalgam - one surface, primary or permanent	$28
D2150	Amalgam - two surfaces, primary or permanent	39
D2160	Amalgam - three surfaces, primary or permanent	46
D2161	Amalgam - four or more surfaces, primary or permanent	57
D2330	Resin-based composite - one surface, anterior	36
D2331	Resin-based composite - two surfaces, anterior	44

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Schedule of Benefits

CDT Codes		Copayments
D2000-D2999	**III. RESTORATIVE – cont.**	
D2332	Resin-based composite - three surfaces, anterior	$58
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	66
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
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
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
D2950	Core buildup, including any pins when required	113
D3000-D3999	**IV. ENDODONTICS**	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50
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
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
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
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
D4910	Periodontal maintenance	32
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
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

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Schedule of Benefits

CDT Codes		Copayments
D5000-D5999	**VI. PROSTHODONTICS (removable) – cont.**	
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 mandibular complete 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
D5900-D5999	**VII. MAXILLOFACIAL PROSTHETICS - Not Covered**	
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
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
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
D6790	Crown - full cast high noble metal	430
D6791	Crown - full cast predominately base metal	430
D6792	Crown - full cast noble metal	430
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
D7285	Biopsy of oral tissue - hard (bone, tooth)	125
D7286	Biopsy of oral tissue - soft	85
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
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
D7810	Open reduction of dislocation	1,800
D7820	Closed reduction of dislocation	1,600
D7830	Manipulation under anesthesia	1,600
D7955	Repair of maxillofacial soft and/or hard tissue defect	1,500

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Schedule of Benefits		
CDT Codes		**Copayments**
D9000-D9999	**XII. ADJUNCTIVE GENERAL SERVICES**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$25
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
D9248	Non-intravenous conscious sedation	125
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
D9940	Occlusal guard, by report	85
	Current Dental Terminology (CDT) @ American Dental Association (ADA)	
	One dental exam and cleaning per 6 month period.	

Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12 month intervals.
Plan Schedule ENY04 is only valid for Covered Services rendered by Participating Dentists in the State of New York.

Guardian Managed DentalGuard products are underwritten by The Guardian Life Insurance Company of America, NY, NY. Limitations and exclusions apply. Products are not available in all states. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Form IP-MDG-NY-EHB-ON-15

This policy provides DENTAL insurance only. The expected benefit ratio of this policy is 60% percent. This ratio is the portion of future premiums that the company expects to return as benefits when averaged over all people with this policy.

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Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D8000-D8999	**XI. ORTHODONTICS**	
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.

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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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