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.

Managed DentalGuard Family Plan—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	$0	Not Covered
Basic Services *Fillings, simple tooth extractions	$69	Not Covered
Major Services *Crowns, inlays, onlays, and cast restorations	$346	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

 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-1-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**
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 radiographs - 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
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 fluoride varnish; therapeutic application for moderate to high caries risk patients, 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
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

Schedule of Benefits

CDT Codes		Plan Schedules - Copayments
D1000-D1999	II. PREVENTIVE – cont.	
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	
	Crowns - single restorations only	
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
D2332	Resin-based composite - three surfaces, anterior	58
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	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 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
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

Schedule of Benefits

CDT Codes		Plan Schedules - Copayments
D2000-D2999	**III. RESTORATIVE – cont.**	
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 tooth bounded spaces per quadrant	165
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 a graft	298
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in a graft	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

Schedule of Benefits

CDT Codes		Plan Schedules - Copayments
D5000-D5999	**VI. PROSTHODONTICS (removable) – cont.**	
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	**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
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

Schedule of Benefits

CDT Codes		Plan Schedules - Copayments
D6200-D6999	IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge]) – cont.	
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
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 cast 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 forcepts 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 palatines	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

Schedule of Benefits

CDT Codes		Plan Schedules - Copayments
D7000-D7999	**X. ORAL AND MAXILLOFACIAL SURGERY – cont.**	
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 maxillofaciial 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
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
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
D9951	Occlusal adjustment – limited	23
D9971	Odontoplasty - 1 - 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
	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	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.

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.