



New York
Voluntary Managed DentalGuard Plans
 Member pays \$5 Office Visit Fee for 3NYM

**Prepaid
 Managed DentalGuard**

Unlimited Maximum Benefits
 Specialist services available by referral
 No deductibles or claim forms required

DentalGuard
 \$1000 Maximum

\$50 deductible in network waived for preventive
 \$100 deductible out of network waived for preventive
 Out of network covered at 80th percentile

Maximum rollover included on groups of 25+ eligible lives
 For Groups of 100+ eligible lives, implants are a covered service
Coinsurance

Sample Covered Charges

Patient Charges

Code	Name	3NYM	UY	
			In Network	Out of Network
Diagnostic and Preventive				
120	Periodic Examination	0	100%	100%
1110	Prophylaxis-adult (teeth cleaning)	0	100%	100%
210	Full mouth x-rays	0	100%	100%
Restorative				
<i>Fillings (amalgam)</i>				
2140	one surface - permanent	17	80%	80%
2150	two surfaces - permanent	22	80%	80%
2160	three surfaces - permanent	26	80%	80%
Endodontics				
<i>Root Canal therapy</i>				
3310	anterior	120	50%	50%
3320	bicuspid	145	50%	50%
3330	molar	370	50%	50%
Periodontics				
4341	Perio scaling & root planing, per quad.	40	80%	80%
4210	Gingivectomy, per quadrant	235	50%	50%
4211	Gingivectomy, per tooth, up to 2 teeth	60	50%	50%
Crown and Bridge				
2740	Porcelain Crown	395	50%	50%
750-52	Porcelain with metal crown**	395	50%	50%
790-92	Cast metal crown**	395	50%	50%
Prosthodontics				
110-20	Complete denture (upper or lower)	452	50%	50%
5213	Partial denture	500	50%	50%
5730	Denture reline (chairside)	110	50%	50%
5750	Denture reline (laboratory)	150	50%	50%
Oral Surgery				
7110	Extract single tooth	22	50%	50%
7510	Incision and drainage of abscess	105	50%	50%
Impactions				
7220	Extract impacted tooth, soft tissue	115	50%	50%
7230	Extract impacted tooth, partial bony	150	50%	50%
7240	Extract impacted tooth, full bony	180	50%	50%
Orthodontia - Comprehensive Treatment*				
	Child to age 18	2425	N/A	N/A
	Member over age 18	2425	N/A	N/A

* The copy listed is for banding only. See the Ortho Schedule of Benefits for a complete listing of all services and copays.
 ** If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

Managed DentalGuard

Orthodontic Services started but not completed prior to the member's eligibility to receive benefits under this plan are excluded.
 Any service or procedure started but not completed prior to the member's eligibility to receive benefits under this plan is excluded.
 Any service or procedure not specifically listed as a benefit is excluded.

Important Information About Managed DentalGuard: This plan provides pre-paid dental benefits through a network of participating general dentists and specialists. All covered services must be provided by the member's Primary Care Dentist. Specialists' services are covered only when referred by the member's Primary Care Dentist and approved in advance by Guardian. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. The Managed DentalGuard plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the Member's effective date under the Managed DentalGuard plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed DentalGuard plan documents are the final arbiter of coverage. GP-1-MDG-NY1, et al.

DentalGuard Dental Insurance Plan General Limitations and Exclusions: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under Preventive Services), orthodontic (unless expressly provided for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. GP-1-DG2000 et al.



New York
Voluntary Managed DentalGuard Community Rates
Member pays \$5 Office Visit Fee for 3NYM

RATES FOR DUAL CHOICE QUOTES

Rates

		Monthly Premium Including \$5.00 Billing Fee	Quarterly Premium Including \$15.00 Billing Fee
Managed DentalGuard			
Coverage Type		Plan Type 3NYM	
Voluntary Plan 3NYM Virgin and Transfer Groups	Employee Only	\$22.48	\$67.44
	Employee + Spouse	\$40.08	\$120.24
	Employee + Child(ren)	\$41.35	\$124.05
	Employee + Family	\$58.83	\$176.49
DentalGuard Network Access Plan			
Coverage Type		Plan Type UY	
Voluntary UY Virgin and Transfer Groups	Employee Only	\$44.89	\$134.67
	Employee + Spouse	\$85.04	\$255.12
	Employee + Child(ren)	\$78.47	\$235.41
	Employee + Family	\$118.75	\$356.25