Guardian

Your dental coverage

PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

This plan covers the pediatric oral care essential health benefits that are compliant with the Affordable Care Act (ACA) requirements. Guardian will ensure that your dependents under age 19 receive the greater coverage between the traditional benefit and the pediatric essential health benefits. Please refer to "Your Pediatric Health Benefit" page for more details.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Your Monthly premium	**$26.35**	
You and Spouse/Domestic Partner	**$53.50**	
You and Child(ren)	**$80.25**	
You, Spouse/Domestic Partner and Child(ren)	**$112.57** (includes the Pediatric Essential Health Benefit)	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	None
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	80%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$2000	$1500
	Combined In-Network and Out-of-Network maximum of $1500 with an additional $500 of benefit In-Network	
Maximum Rollover	Yes	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover In-network Amount	$500	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$1500	
Dependent Age Limits	26	

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	80%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	80%
	Limits:	Under Age 19	
	Oral Exams	100%	80%
	Sealants (per tooth)	100%	80%
	X-rays	100%	80%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian

Your dental coverage

Manage Your Benefits:	Find A Dentist:
Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..	Visit www.Guardianlife.com Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: 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), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), 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. Contract # GP-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

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Your dental coverage

Pediatric Essentials – As highlighted on the "Dental Plans" page, this plan covers the pediatric oral care essential health benefits that are compliant with the Affordable Care Act (ACA) requirements. Guardian will ensure that your dependents Under Age 19 receive the greater coverage between the traditional benefit and the pediatric essential health benefits.

Your Dental Plan		
Your Network is	DentalGuard Preferred	
Calendar Year Deductible	*In-Network*	*Out-of-Network*
Per Insured Child (Orthodontic & Non-Orthodontic)	$50	$50
Waived for	Preventive	Not Waived
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Diagnostic & Preventive - Oral Exam, Cleaning, X-rays, Fluoride	100%	80%
Basic Care - Fillings, Stainless Steel Crowns, Extractions	80%	60%
Major Care -Endodontic Services, Crown Restorations	50%	50%
Orthodontia – **Medically Necessary Only**	50%	50%
Annual Maximum	None	None
Lifetime Orthodontia Maximum	None	None
Out Of Pocket Annual Maximum		
Individual	$350	Not Applicable
Family	$700	Not Applicable
Age Limits	Under Age 19	

This is only a partial list of dental services. Your certificate of benefits will show what is covered and excluded. Plan and rates subject to change based on state requirements.

Medically Necessary Orthodontics – includes, but may not be limited to, orthodontic treatment of skeletal, dental and/or occlusal conditions due to cleft palate and resulting in severe or handicapping malocclusion. Medically necessary orthodontics does not include orthodontic treatment performed solely for crowded dentitions (crooked teeth), excessive spacing between teeth and/or having horizontal/vertical (overjet/overbite) discrepancies.

Out of Pocket Annual Maximum – The Preferred Provider Out of Pocket Annual Maximum will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.

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Policy Form # GP-1-DG2000, et al, GP-1-DEN-16