Guardian

Guardian® Basics for Families and Individuals

- See any dentist you want but you can save more when you visit a dentist that participates in Guardian's DentalGuard Preferred network. As one of the largest networks nationwide, chances are your dentist is already participating. Charges for services provided by participating dentists are reimbursed directly from Guardian.
- Get most preventive services, such as oral exams, cleanings and x-rays covered at 100% once the annual deductible has been reached.
- You can choose to see a dentist outside of the network and you'll be reimbursed based on the lower of your dentist's fees, or the maximum allowable charge, which is the amount that would be paid to dentists who have agreed to be reimbursed according to a negotiated fee schedule. You would be responsible for any amounts over the maximum allowable charge as well as any co-insurance.

Summary Of Benefits
For Adults 19 and Over

	In-Network	Out-of-Network
Deductibles *What you pay out-of-pocket before the plan pays benefits*	**You Pay**	
Individual	$60	$60
Family *(3 or more insured adults)*	$180	$180
Plan Maximum *Applies to members 19 and over. The maximum amount that you can be reimbursed for services received*		
Annual Maximum	$1500	$1500
Co-insurance *The amount Guardian pays toward the cost of a covered charge*	**Guardian Pays**	
Preventive Services *Most routine dental services, including: oral exams, cleanings, x-rays*	100%	100%
Basic Services *Simple restorative services (fillings), diagnostic services, endodontic services, periodontal services and oral surgery*	60% *After 6 month waiting period**	60% *After 6 month waiting period**

**The waiting period is the initial time period following the effective date of coverage for which no benefits would be paid. Applies to members age 19 and older.*

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- See any dentist you want but you can save more when you visit a dentist that participates in Guardian's DentalGuard Preferred network. As one of the largest networks nationwide, chances are your dentist is already participating. Charges for services provided by participating dentists are reimbursed directly from Guardian.
- Get most preventive services, such as oral exams, cleanings and x-rays covered at 100% once the annual deductible has been reached.
- **This plan also includes the pediatric dental Essential Health Benefit (EHB) as mandated by the Affordable Care Act (ACA), which is a comprehensive set of dental services for children under age 19.**
- You can choose to see a dentist outside of the network and you'll be reimbursed based on the lower of your dentist's fees, or the maximum allowable charge, which is the amount that would be paid to dentists who have agreed to be reimbursed according to a negotiated fee schedule. You would be responsible for any amounts over the maximum allowable charge as well as any co-insurance.

Summary Of Benefits For Children under 19	In-Network	Out-of-Network
Deductibles *What you pay out-of-pocket before the plan pays benefits*	**You Pay**	
Per child	$250	$250
Out of Pocket Maximum *Applies to members under 19 only. Once this amount is reached, Guardian will pay 100% of your child's dental charges for the rest of the year.*		
Individual *(One Child)*	$350	$350
Family *(2 or more Children)*	$700	$700
Co-insurance *The amount Guardian pays toward the cost of a covered charge*	**Guardian Pays**	
Preventive Services *Most routine dental services, including: oral exams, cleanings and x-rays*	100%	100%
Basic Services *Simple restorative services (fillings) and diagnostic services*	80%	80%
Major Services *More complex dental services including: crowns, complex extractions, oral surgery, periodontal and endodontic services*	50%	50%
Medically Necessary Orthodontia *Applies to members under age 19 only*	50%	50%

Limitations and Exclusions for Guardian Basics PPO Plans

The Limits and Exclusions listed here apply to Covered Persons age 19 and older.

Exclusions

Covered Services and Supplies do not include:

1. Treatment which is: a) not included in the list of Covered Services and Supplies; b) not Dentally Necessary; or c) Experimental in nature.
2. Any Charges which are: a) Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Plan will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies; b) Not imposed against the person or for which the person is not liable; c) Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is: a) a Close Relative or a person who ordinarily resides with You or a Dependent; b) an Employee of the Employer; c) the Employer.
5. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least 3 years, as determined by the Plan.
6. All services for which a claim is received more than 6 months after the date of service.
7. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
8. Services and supplies provided primarily for cosmetic purposes.
9. Services and supplies obtained while outside of your covered state and/or the United States, except for Emergency Dental Care.
10. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
11. Diagnostic casts.
12. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
13. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
14. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
15. Veneers
16. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
17. Replacement of a lost or stolen Appliance or Prosthesis.
18. Replacement of stayplates.
19. Extraction of pathology-free teeth, including supernumerary teeth. (unless for medically necessary orthodontia)
20. Socket preservation bone graphs
21. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
22. Treatment for a jaw fracture.
23. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
24. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
25. Oral sedation and nitrous oxide analgesia are not covered.
26. Therapeutic drug injection.
27. Completion of claim forms.
28. Missed dental appointments.
29. Replacement of missing teeth prior to coverage effective date

Limitations and Exclusions for Guardian Basics PPO Plans

The Exclusions listed here apply to Covered Persons under the age of 19.

Covered Services and Supplies do not include:

1. Treatment which: a) is not included in the list of Covered Services and Supplies; b) is not Dentally Necessary; or c) is Experimental in nature.
2. Any Charges which are:

a) Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.

b) Not imposed against the person or for which the person is not liable.

c) Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.

3. Services or supplies resulting from or in the course of Your or Your Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is: a) a Close Relative or a person who ordinarily resides with You or a Dependent; b) an Employee of the Employer; c) the Employer.
5. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least three years, as determined by the Plan.
6. All services for which a claim is submitted more than 6 months after the date of service.
7. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
8. Services and supplies provided primarily for cosmetic purposes.
9. Covered services and supplies obtained while outside of the United States, except for Emergency Dental Care.
10. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
11. Diagnostic casts, unless for medically necessary orthodontia.
12. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
13. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
14. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.
15. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
16. Replacement of a lost or stolen Appliance or Prosthesis.
17. Replacement of stayplates.
18. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
19. Treatment for a jaw fracture
20. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
21. Therapeutic drug injection
22. Completion of claim forms
23. Missed dental appointments
24. Porcelain and cast crowns
25. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam resin filling.
26. Pathology free third molar extraction or removal
27. Crown build-up is not covered as a separate service
28. Temporary tooth stabilization, other than covered space maintainers, is not covered
29. Oral sedation and nitrous oxide analgesia are not covered, except for Children through age 13
30. Implants, and procedures and appliances associated with them, are not benefits of Guardian programs
31. Replacement of missing teeth prior to coverage effective date.