Guardian

Guardian® Preventive Plus 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 - This document is provided for summary purposes only and is not a complete description of plan benefits, limitations, and exclusions. Read your plan documents for details on plan benefits, limitations, and exclusions.

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	$50	$100
Family *(3 or more insured adults)*	$150	$300
Plan Maximum *Applies to members 19 and over. The maximum amount that you can be reimbursed for services received.*		
Annual Maximum	$1000	$1000
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 and non-surgical extractions.*	50% *After 6 month waiting period**	50% *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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- ❑ 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 - This document is provided for summary purposes only and is not a complete description of plan benefits, limitations, and exclusions. Read your plan documents for details on plan benefits, limitations, and exclusions.

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	$50	$100
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)*	$450	n/a
Family *(2 or more Children)*	$900	n/a
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%	90%
Basic Services *Simple restorative services (fillings) and diagnostic services.*	50%	40%
Major Services *More complex dental services including: crowns, complex extractions, oral surgery, periodontal and endodontic services.*	50%	40%
Medically Necessary Orthodontia *Applies to members under age 19 only.*	50%	30%

Limitations and Exclusions for Guardian Preventive Plus PPO Plans

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

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition requiring services or supplies for the treatment of an Occupational Injury or Sickness which are payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty. Benefits are available for cosmetic services needed to treat medically diagnosed congenital defects or anomalies for minor children with cleft lip or cleft palate.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition. Benefits are available for treatment needed to treat medically diagnosed congenital defects or anomalies for minor children with cleft lip or cleft palate.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment, unless the benefit provision provides specific benefits for Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplants.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Evaluations or treatment for Endodontics, Periodontics or Oral Surgery are not a covered benefit under this Plan.

Limitations and Exclusions for Guardian Preventive Plus PPO Plans

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

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty. Benefits are available for cosmetic services needed to treat medically diagnosed congenital defects or anomalies for minor children with cleft lip or cleft palate.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition. Benefits are available for treatment needed to treat medically diagnosed congenital defects or anomalies for minor children with cleft lip or cleft palate.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic other than as outlined under the List of Covered Dental Services below.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

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Guardian Dental is underwritten by The Guardian Life Insurance Company of America, New York, NY. Policy limitations and exclusions apply. Plan documents are the final arbiter of coverage. Individual Policy Form IP-DENF-27-NC. This plan may not be available in all Counties. Please visit the See Plans and Prices section at www.healthcare.gov to confirm availability in your area.
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