Guardian

Guardian® Basics for Families and Individuals

- This is an Indemnity plan. You may receive dental care from any licensed dentist. Covered charges are the lesser of: (a) the Dentist's actual changes; and (b) reasonable and customary charges for the dental services named in the Policy's List of Covered Dental Services.
- Get most preventive services, such as oral exams, cleanings and x-rays covered at 100% once the annual deductible has been reached.

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

Deductibles *What you pay out-of-pocket before the plan pays benefits*	**You Pay**
Individual	$50
Family *(3 or more insured adults)*	$150
Plan Maximum *Applies to members 19 and over. The maximum amount that you can be reimbursed for services received*	
Annual Maximum	$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%
Basic Services *Simple restorative services (fillings), diagnostic services, endodontic services, periodontal services and oral surgery*	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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- This is an Indemnity plan. You may receive dental care from any licensed dentist. Covered charges are the lesser of: (a) the Dentist's actual changes; and (b) reasonable and customary charges for the dental services named in the Policy's List of Covered Dental Services.
- 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.**

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

Deductibles *What you pay out-of-pocket before the plan pays benefits*	**You Pay**
Per child	$50
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)*	$400
Family *(2 or more Children)*	$800
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%
Basic Services *Simple restorative services (fillings) and diagnostic services*	50%
Major Services *More complex dental services including: crowns, complex extractions, oral surgery, periodontal and endodontic services*	50%
Medically Necessary Orthodontia *Applies to members under age 19 only*	50%

Limitations and Exclusions for Guardian Basics Plans

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

Limitations

Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

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, 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.
- 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.
- 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.
- 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.

Limitations and Exclusions for Guardian Basics Plans

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

Limitations

Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after the Covered Dependent became covered by this Plan.

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.
- 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.
- 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.
- 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.
- Orthodontic Treatment that is not medically necessary.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- 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.
- Pulp vitality tests or caries susceptibility tests.
- Prescription medication