Guardian

Guardian Managed DentalGuard - NY

Coverage Summary

(see your policy for further details)

Choose any Dentist

In-Network Dentist	Under this plan, you must be assigned to a Primary Care Dentist of your choice from our Network of contracted providers. All care must be provided or arranged by your Primary Care Dentist.
Out-of-Network Dentist	No coverage

Your Plan Benefits	Guardian Pays Waiting period is the time period following the coverage start date during which no benefits are paid
Preventive Services Most routine dental services, including oral exams, cleanings, x-rays, topical fluoride	Most preventive services covered at 100% without any copay No waiting period Sample Copays: (see full copay schedule below) • Prophylaxis (dental cleaning) first 2 services in any 12-month period = $0 • Sealant – per tooth (molars) = $14
Basic Services Moderately complex dental services, including fillings and simple extractions	100% less your copay No waiting period Sample Copays: (see full copay schedule below) • Filling (amalgam – one surface; primary or permanent) = $28 • Simple extraction (extraction, erupted tooth or exposed root removal) = $35

Major Services More complex dental services including crowns, complex extractions, oral surgery, periodontal, and endodontic services	100% less your copay No waiting period Sample Copays: (see full copay schedule below) • Endodontic (root canal) therapy bicuspid tooth (excluding final restoration) = $300 • Crowns (porcelain/ceramic substrate) = $450
Implants	0% Not covered
Orthodontia	100% less your copay No waiting period Sample Copays: (see full copay schedule below) • Children under 19 = $350 (note: copay in schedule of benefits below is higher, but is capped by the Out-of-Pocket Maximum for children under 19) • Adults 19 and over = $2,800
Special Affordable Care Act (ACA) Pediatric Dental Benefit	This plan 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. See full copayment schedule below for details. --- This policy provides DENTAL insurance only. The expected benefit ratio for this policy is 55 percent. This ratio is the portion of future premiums that the company expects to return as benefits, when averaged over all people with this policy.

Office Visit Charges Flat charge per office visit in addition to your copay for each procedure	You Pay (per insured member)
Charge for each Office Visit	$18

Deductibles What you pay out-of-pocket before your plan pays benefits	You Pay
Preventive Services	$0
All Other Dental Services	$0

Maximum Payouts The maximum amount Guardian will reimburse you for dental services received	Maximum Guardian Pays
Total Benefit Maximum	No maximum
Implant Maximum	Not covered
Orthodontia Maximum	No maximum

Your Out-of-Pocket Maximum (for Children under 19 Only) Once you pay this amount, Guardian will pay 100% of your child's dental charges for the rest of the year	Maximum You Pay (for Children under 19 Only)
1 insured child	$350
2 or more insured children	$700

Copayment Schedule
Full Copay Schedule (/sites/default/files/inline-files/MDG-FP-U10NYI04-SCH-NY-OFF-17%20Issue%20Document_3.pdf)

Limitations and Exclusions (see your policy for further details)

No coverage is available under this Policy for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g. certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Policy unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in the Pediatric Dental Care section of this Policy.

E. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

F. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

G. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

H. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

I. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

J. Medically Necessary.
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Policy.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M.No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile nofault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Pre-Existing Conditions.
For a period of 12 months from the enrollment date, We do not Cover any conditions for which medical advice was given, treatment was recommended by or received from a physician within six (6) months before the effective date of Your coverage. We will not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information. The pre-existing condition exclusion does not apply to the pediatric dental essential health benefit.

O.Services Not Listed.
We do not Cover services that are not listed in this Policy as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

Q.Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses.

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Dental DHMO coverage in New York is underwritten by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all counties. Note: Procedures listed above are for sample purposes only and do not encompass all covered services. Actual patient charges will vary based on the procedure and are listed on the full co-payment schedule. Policy limitations and exclusions apply. Please refer to your plan documents for a complete list of limitations and exclusions. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only.

Policy Form IP-MDG-DHMO-NY-FP-OFF-17

A10/2018

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