Guardian

BENEFITS		
	Base (Low) Plan Option	
	In-Network	Out-of-Network
Coinsurance	100/80/0	100/80/0
DentalGuard Preferred Network Tiers	DentalGuard Preferred	Out-of-Network
Deductible	**$50**	
Period	Calendar Year	
Family Limit	3 per family	
Waived For	Preventive	Preventive
Annual Maximum	**$1,000**	**Maximums for In-Network and Out-of-Network are inclusive**
Claim Payment Basis	Negotiated Fee Schedule	95th
Coinsurance - Preventive	**100%**	**100%**
	• Oral Exams (twice/12 mos.) • Cleanings (twice/12 mos.) • X-Rays (Full-mouth series once/60 mos.) • Fluoride Treatment (to age 19, twice/12 mos.) • Sealants (to age 16, once/36 mos.) • Space Maintainers/Harmful Habit Appliances	
Coinsurance - Basic	**80%**	**80%**
	• Fillings (include posterior composites) • Perio Maintenance Procedure (twice/12 mos.) • Periodontal Services (eg Scaling and Root Planing) • Simple Extractions • Endodontic Services (eg. Root Canal)	
Coinsurance - Major	**Not Covered**	**Not Covered**
	• Bridges & Dentures • Single Crowns • Complex Extractions • Repair & Maintenance of Crowns, Bridges & Dentures • General Anesthesia • Periodontal Surgery • Inlays, Onlays & Veneers	
Dependent Age Limits	To Age 26	
Waiting Periods	None	
Plan Type & Code	Network Access Plan (PX - 10)	
Dental Contract	DentalGuard 7	

RATES				
	Plan #1			
	Employee	Employee & Spouse	Employee & Child(ren)	Full Family
Monthly Rate	$26.30	$52.49	$49.48	$82.56