Guardian Dental and Vision Plans

00517181

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

Dental and Vision

Dental Plans

Option 1 or 2 or 3: With your Basic Plan or Enhanced Plan or 50% Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	Option 1: Basic Plan		Option 2: Enhanced Plan		Option 3: 50% Plan	
Network	DentalGuard Preferred		DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-Network*	*In-Network*	*Out-Network*	*In-Network*	*Out-Network*
Individual	$0	$0	$0	$0	$0	$0
Family limit	Not Applicable		Not Applicable		Not Applicable	
Waived for	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Charges covered for you (co-insurance)	*In-Network*	*Out-Network*	*In-Network*	*Out-Network*	*In-Network*	*Out-Network*
Preventive Care	100%	100%	100%	100%	50%	50%
Basic Care	100%	100%	100%	100%	50%	50%
Major Care	80%	80%	80%	80%	50%	50%
Orthodontia	80%	80%	80%	80%	50%	50%
Annual Maximum Benefit	$1500	$1500	$2500	$2500	$1000	$1000
Maximum Rollover	Yes		Yes		Yes	
Rollover Threshold	$700		$900		$500	
Rollover Amount	$350		$450		$250	
Rollover In-network Amount	$500		$500		$350	
Rollover Account Limit	$1250		$1250		$1000	
Lifetime Orthodontia Maximum	$2000		$3000		$1500	
Dependent Age Limits	26		26		26	

CATEGORY	PLAN DETAILS	Option 1: Basic Plan *Plan pays (on average)*		Option 2: Enhanced Plan *Plan pays (on average)*		Option 3: 50% Plan *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%	50%	50%
	Frequency:	2 in 12 Months		2 in 12 Months		2 in 12 Months	
	Fluoride Treatments	100%	100%	100%	100%	50%	50%
	Limits:	Under Age 19		Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%	50%	50%
	Sealants (per tooth)	100%	100%	100%	100%	50%	50%
	X-rays	100%	100%	100%	100%	50%	50%
Basic Care	Anesthesia*	100%	100%	100%	100%	50%	50%
	Fillings+	100%	100%	100%	100%	50%	50%
	Perio Surgery	100%	100%	100%	100%	50%	50%
	Periodontal Maintenance	100%	100%	100%	100%	50%	50%
	Frequency:	Once Every 6 Months (Standard)		Once Every 6 Months (Standard)		Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	100%	100%	100%	100%	50%	50%
	Root Canal	100%	100%	100%	100%	50%	50%
	Scaling & Root Planing (per quadrant)	100%	100%	100%	100%	50%	50%
	Simple Extractions	100%	100%	100%	100%	50%	50%
	Surgical Extractions	100%	100%	100%	100%	50%	50%
Major Care	Bridges and Dentures	80%	80%	80%	80%	50%	50%
	Dental Implants	80%	80%	80%	80%	50%	50%
	Inlays, Onlays, Veneers**	80%	80%	80%	80%	50%	50%
	Single Crowns	80%	80%	80%	80%	50%	50%
Orthodontia	Orthodontia	80%	80%	80%	80%	50%	50%
	Limits:	Adults & Child(ren)		Adults & Child(ren)		Adults & Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia - restrictions apply. +For PPO and or Indemnity members, Fillings- restrictions may apply to composite fillings.

Option 1: Visit any doctor with your Full Feature plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Option 2: Your Exam Plus plan covers an eye exam and provides discounts on glasses and contact lens professional services.

Your Vision Plan	**Option 1: Base Plan**	**Option 2: Exam Only Plan**
Network	VSP Choice Network	VSP Choice Network
Copay		
Exams Copay	$ 10	$ 10
Materials Copay (waived for elective contact lenses)	$ 15	Not Applicable
Service Frequencies		
Exams	Every calendar year	Every calendar year
Lenses (*for glasses or contact lenses*) ‡‡	Every calendar year	Not Applicable
Frames	Every calendar year	Not Applicable
Network discounts (cosmetic extras, glasses and contact lens professional service)	Limitless within 12 months of exam.	Limitless within 12 months of exam.
Dependent Age Limits	26	26

‡‡Benefit includes coverage for glasses or contact lenses, not both.

PLAN DETAILS	OPTION 1: BASE PLAN		OPTION 2: EXAM ONLY PLAN	
	You pay (after copay if applicable):		*You pay (after copay if applicable):*	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Eye Exams	$0	Amount over $39	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23	20% off retail price	No discounts
Lined Bifocal Lenses	$0	Amount over $37	20% off retail price	No discounts
Lined Trifocal Lenses	$0	Amount over $49	20% off retail price	No discounts
Lenticular Lenses	$0	Amount over $64	20% off retail price	No discounts
Frames	80% of amount over $100	Amount over $46	20% off retail price	No discounts
Contact Lenses *(Elective)*	Amount over $175	Amount over $100	No discounts	No discounts
Contact Lenses *(Medically Necessary)*	$0	Amount over $210	No discounts	No discounts
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts	Avg. 20% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts	Up to 15% off the usual charge or 5% off promotional price	No discounts

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

*** For the discount to apply your purchase must be made within 12 months of the eye exam.*

For VSP, only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future
purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.