



Summary of Benefits

Dental Benefit Summary

Group ID:	00447241	Coverage Type:	Contributory
Group Name:	CITY OF WOODSTOCK	Class:	0001 ALL OTHER ELIGIBLE EMPLOYEES WORKING 30 OR MORE HOURS PER WEEK
Waiting Period:	1st of the month following date of hire	As of Date:	10/01/2023

Plan Information

Your dental networks are: Dental - DentalGuard Pref - Atlanta and Dental - DentalGuard Pref NAP - Atlanta

Coverage Information

	Dental - DentalGuard Pref - Atlanta		Dental - DentalGuard Pref NAP - Atlanta	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the Dental - DentalGuard Pref - Atlanta network will be most cost effective.		You may go to any dentist, however those who belong to the Dental - DentalGuard Pref NAP - Atlanta network will be most cost effective.	
	In Network	Out of Network	In Network	Out of Network
Calendar year deductible	None	None	Out of Network is a combined deductible for in and out of network services.	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive				Waived
Basic				Not Waived
Major				Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	\$1,000	The amount shown in the out of network field is your combined Calendar Year	\$1,000

	Dental - DentalGuard Pref - Atlanta		Dental - DentalGuard Pref NAP - Atlanta	
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	In Network	Out of Network	In Network	Out of Network

maximum for both in and out of network services.

Lifetime Orthodontia Maximum	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	\$1,000	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	\$1,000
Maximum rollover	Yes	Yes	Yes	Yes
Monthly Switch	Not Available	Not Available	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?	How much does the plan pay?	How much does the plan pay?
Office Visit Co-pay (one office visit may cover multiple services)	None	None	None	None
Preventive Care:	100%	100%	100%	100%
Bitewing X-Rays	100%	100%	100%	100%
Full Mouth X-Rays	100%	100%	100%	100%
Cleaning	100%	100%	100%	100%
Oral Exams	100%	100%	100%	100%
Sealants (per tooth)	100%	100%	100%	100%
Basic Care:	100%	100%	80%	80%
Fillings (one surface)	100%	100%	80%	80%
General Anesthesia ¹	100%	100%	80%	80%
Simple Extractions	100%	100%	80%	80%
Major Care:	60%	60%	50%	50%

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	In Network	Out of Network	In Network	Out of Network
Scaling & Root Planing (per quadrant)	60%	60%	50%	50%
Dentures	60%	60%	50%	50%
Single Crowns	60%	60%	50%	50%
Orthodontia	50%	50%	50%	50%

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).
- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DEN -16 et al.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

 1 Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.