

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: VD without Ortho	Name of Product: DentalGuard
Type or Product Line: DPPO	Plan Phone #: 1-888-Guardian
Effective Date: Beginning on or after 1/1/2023	Plan Website: guardianlife.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT GUARDIANLIFE.COM OR CALL 1-888-GUARDIAN. THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Per Individual \$ 25	Per Individual \$ 50

The deductible applies to all services except Preventive.
A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
In-network services are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
Out-of-network services are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	\$ 1,500	\$ 1,500

Annual maximum is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
Lifetime maximum means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **There is no waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
<i>Oral Exam</i>	Preventive	0%, deductible does not apply	0%, deductible does not apply	1 in 6 Months - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Bitewing X-ray</i>	Preventive	0%, deductible does not apply	0%, deductible does not apply	
<i>Cleaning</i>	Preventive	0%, deductible does not apply	0%, deductible does not apply	1 in 6 Months - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Filling</i>	Basic	10%	20%	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	10%	20%	
<i>Root Canal</i>	Basic	10%	20%	
<i>Scaling and Root Planing</i>	Basic	10%	20%	
<i>Ceramic Crown</i>	Major	40%	50%	
<i>Removable Partial Denture</i>	Major	40%	50%	
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	10%	20%	
<i>Orthodontia</i>	Orthodontia	100%	100%	Orthodontia is not covered under this plan. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.