

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Z2	Name of Product: DentalGuard
Type of Product Line: DPPO	Plan Phone #: 1-888-Guardian
Class: 0002	Plan Website: guardianlife.com
Effective Date: Beginning on or after 10/01/21	

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 INSURER WEBSITE AT GUARDIANLIFE.COM OR CALL 1-888-GUARDIAN.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

<u>Deductible</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Dental	Per Individual \$25 (no more than 2 deductibles per family)	Per Individual \$25 (no more than 2 deductibles per family)
Orthodontia	None	None

- ☐ **The deductible applies to all services except in-network preventive services.**
- ☐ 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

<u>Maximums</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum	\$2,000	\$2,000
Lifetime or Annual Maximum for Orthodontia	Lifetime \$2,000	Lifetime \$2,000

- ☐ **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 for all or certain dental treatments.

A 12 month waiting period applies to major services.

A 12 month waiting period applies to orthodontic services.

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.

<u>Common Dental Procedures</u>	<u>Category</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Limitations and Exclusions</u>
<i>Oral Exam</i>	Preventive & Diagnostic	0%, Deductible does not apply.	20%	2 per calendar year - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	0%, Deductible does not apply.	20%	2 per calendar year - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Cleaning</i>	Preventive & Diagnostic	0% , Deductible does not apply.	20%	1 per calendar year - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.

<u>Common Dental Procedures</u>	<u>Category</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Limitations and Exclusions</u>
<i>Filling</i>	Basic	10%	20%	Once per tooth every 12 months for those under the age of 19, and once per tooth every 36 months for those age 19 and older - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<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>	Basic	10%	20%	
<i>Removable Partial Denture</i>	Major	40%	50%	
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	10%	20%	
<i>Orthodontia</i>	Orthodontia	50%	Not Covered	Orthodontia applies to Child and Adult - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana's Has a Dental Appointment with a New Dentist		Sam Needs a Tooth Filled		Maria's Needs a Crown	
New patient exam, x-rays (FMX) and cleaning		Resin-based composite - one surface, posterior		Crown - porcelain/ceramic substrate	
Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: \$250	Total Cost of Care	In-network: \$150	Total Cost of Care	In-network: \$950
	Out-of-network: \$450		Out-of-network: \$250		Out-of-network: \$1,400
Deductible	In-network: Not Applicable	Deductible	In-network: \$25	Deductible	In-network: \$25
	Out-of-network: \$25		Out-of-network: \$25		Out-of-network: \$25
Annual Maximum (Plan Will Pay)	In-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000
	Out-of-network: \$2,000		Out-of-network: \$2,000		Out-of-network: \$2,000
Patient Cost (copayment or coinsurance)	In-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 10%	Patient Cost (copayment or coinsurance)	In-network: 10%
	Out-of-network: 20%		Out-of-network: 20%		Out-of-network: 20%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$0.00	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$37.50	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$117.50
	Out-of-network: \$110.00		Out-of-network: \$70.00		Out-of-network: \$300.00
Summary of what is not covered or subject to a limitation:	Exam, x-rays and cleaning are subject to frequency limitations.	Summary of what is not covered or subject to a limitation:	Fillings paid once per tooth in 12 months if under age 19, and once per tooth in 36 months if over age 19. If plan does not include posterior composite coverage, an amalgam benefit will be paid on posterior teeth.	Summary of what is not covered or subject to a limitation:	Plan does not include porcelain coverage on posterior teeth, a metal crown benefit will be paid.