Summary of Benefits

Dental Benefit Summary

Group ID:	00444666	Coverage Type:	Voluntary
Group Name:	LANG MASONRY CONTRACTORS INC.	Class:	ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 90 day(s)	As of Date:	10/16/2024

Plan Information

Your dental networks is: Dental - DentalGuard Pref NAP - Ohio

Coverage Information

	Dental - DentalGuard Pref NAP - Ohio	
What's the most cost-effective way to use dental insurance?	With your PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.	
	In Network	Out of Network
Calendar year deductible	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
Maximum rollover	Not Available	Not Available
Monthly Switch	Not Available	Not Available
	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
Preventive Care:	100%	100%
Bitewing X-Rays	100%	100%
Full Mouth X-Rays	100%	100%
Cleaning	100%	100%
Oral Exams	100%	100%
Sealants (per tooth)	100%	100%
Basic Care:	75%	75%
Fillings (one surface)	75%	75%
General Anesthesia[1]	75%	75%
Scaling & Root Planing (per quadrant)	75%	75%
Simple Extractions	75%	75%
Major Care:	0%	0%
Dentures	0%	0%
Single Crowns	0%	0%
Orthodontia	Not Available	Not Available

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.