CA-Dental Benefits and Coverage Disclosure

Part I: GENERAL INFORMATION

Plan Name: Plan #1 (ZY)	Name of Product: DentalGuard
Type of Product Line: DPPO	Plan Phone #: 1-888-Guardian
Effective Date: 12/01/24-11/30/25	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(no more than 3 deductibles per family)	Per Individual $25(no more than 3 deductibles per family)
Orthodontia	None	None

The deductible applies to all services except In-Network 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	$1500	$1500
Lifetime or Annual Maximum for Orthodontia	Lifetime $1000	Lifetime $1000

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.

No waiting periods apply.

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.

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Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	0%, deductible does not apply	0%	2 per calendar. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Bitewing X-ray	Preventive & Diagnostic	0%, deductible does not apply	0%	
Cleaning	Preventive & Diagnostic	0%, deductible does not apply	0%	2 per calendar. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Filling	Basic	20%	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 Detailed Description of Coverage Benefits and Limitations.
Extraction, Erupted Tooth or Exposed Root	Basic	20%	20%	
Root Canal	Basic	20%	20%	
Scaling and Root Planing	Basic	20%	20%	
Ceramic Crown	Major	50%	50%	
Removable Partial Denture	Major	50%	50%	
Extraction, Erupted Tooth with Bone Removal	Basic	20%	20%	
Orthodontia	Orthodontia	50%	50%	This benefit is available only for those under the age of 19 when the orthodontic appliances are first placed. 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.

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Dana Has a Dental Appointment with a New Dentist		Sam Needs a Tooth Filled		Maria 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 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400
Deductible	In-network: Not Applicable Out-of-network: $25	Deductible	In-network: $25 Out-of-network: $25	Deductible	In-network: $25 Out-of-network: $25
Annual Maximum (Plan Will Pay)	In-network: $1500 Out-of-network: $1500	Annual Maximum (Plan Will Pay)	In-network: $1500 Out-of-network: $1500	Annual Maximum (Plan Will Pay)	In-network: $1500 Out-of-network: $1500
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $25	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $50 Out-of-network: $70	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $488 Out-of-network: $713
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:	If plan does not include porcelain coverage on posterior teeth, a metal crown benefit will be paid.