Summary of Benefits

Dental Benefit Summary

Group ID:	00396578	**Coverage Type:**	Contributory
Group Name:	THE JAMES B. OSWALD, CO.	**Class:**	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 30 day(s)	**As of Date:**	07/01/2017

Plan Information

Your dental networks are: Managed Dental Care- Managed DentalGuard, Inc - (OH) , Managed Dental Care- First Commonwealth Limited Health Services Corporation of Michigan (MI) and Dental - DentalGuard Pref - Ohio

Coverage Information

	Managed Dental Care- Managed DentalGuard, Inc - (OH)	**Managed Dental Care- First Commonwealth Limited Health Services Corporation of Michigan (MI)**	**Dental - DentalGuard Pref - Ohio**	
What's the most cost-effective way to use dental insurance?	You are only covered if you go to a dentist who belongs to the **Managed Dental Care - Managed DentalGuard, Inc - (OH)** network.	You are only covered if you go to a dentist who belongs to the **Managed Dental Care - First Commonwealth Limited Health Services Corporation of Michigan (MI)** network.	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Ohio** network will be most cost effective.	
			In Network	Out of Network
Calendar year deductible	None	None	$50, Once the annual deductible is met by each of two family members, no further deductibles apply.	$50, Once the annual deductible is met by each of two family members, no further deductibles apply.
Preventive	None	None	Waived	Waived
Basic	None	None	Not Waived	Not Waived
Major	None	None	Not Waived	Not Waived
Calendar Year Maximum Benefit	Unlimited	Unlimited	The amount shown in the out of network field is your combined Calendar Year	$1,500

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			In Network	Out of Network
			maximum for both in and out of network services.	
Lifetime Orthodontia Maximum	Not Applicable	Not Applicable	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	$1,500
Maximum rollover	Not Applicable	Not Applicable	Yes	Yes
Monthly Switch	Not Available	Not Available	Not Available	Not Available
	How much will it cost?	How much will it cost?	How much does the plan pay?	How much does the plan pay?(as a percentage of reasonable and customary.)
Office Visit Co-pay (one office visit may cover multiple services)	$10	$10	None	None
Preventive Care:	May be an additional fee	May be an additional fee	100%	100%
Bitewing X-Rays	May be an additional fee	May be an additional fee	100%	100%
Full Mouth X-Rays	May be an additional fee	May be an additional fee	100%	100%
Cleaning	May be an additional fee	May be an additional fee	100%	100%
Oral Exams	May be an additional fee	May be an additional fee	100%	100%
Sealants (per tooth)	May be an additional fee	May be an additional fee	100%	100%
Basic Care:	May be an additional fee	May be an additional fee	100%	80%
Fillings (one surface)	May be an	May be an additional fee	100%	80%

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			In Network	Out of Network
	additional fee			
General Anesthesia[1]	May be an additional fee	May be an additional fee	100%	80%
Scaling & Root Planing (per quadrant)	May be an additional fee	May be an additional fee	100%	80%
Simple Extractions	May be an additional fee	May be an additional fee	100%	80%
Major Care:	May be an additional fee	May be an additional fee	60%	50%
Dentures	May be an additional fee	May be an additional fee	60%	50%
Single Crowns	May be an additional fee	May be an additional fee	60%	50%
Orthodontia	Consult Your Benefit Booklet	Consult Your Benefit Booklet	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.

Important information about Guardian's Managed Dental Care Plans:

This plan provides dental benefits through a network of participating general dentists and specialty care dentists. All covered services must be provided by the member's Primary Care Dentist. Specialty care services are covered only when referred by the member's Primary Care Dentist and approved in advance by Managed Dental Care. Only

those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. The Managed Dental Care plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed Dental Care plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed Dental Care plan documents are the final arbiter of coverage. GP-1-MDG1, et al. (Florida), GP-1MDC1, et al. (California), GP-1-MDG-TX1, et al. (Texas), GP-1-MDG-NY1, et al. (New York), GP-1-MDG-1-NJ, et al. (New Jersey)

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.