Summary of Benefits

Dental Benefit Summary

Group ID:	00529922	Member Coverage Type:	Non Contributory
Group Name:	MARCHESE FORD OF MECHANICVILLE	Dependent Coverage Type:	Contributory
Waiting Period:	1st of the month following 90 day(s)	Class:	0001 ALL ELIGIBLE EMPLOYEES
		As of Date:	07/29/2022

Plan Information

Your dental networks is: Dental - DentalGuard Pref - Syracuse

Coverage Information

	Dental - DentalGuard Pref - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Syracuse** network will be most cost effective.	
	In Network	Out of Network
Calendar year deductible	$25, Once the annual deductible is met by each of three family members, no further deductibles apply.	$25, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive	Waived	Waived
Basic	Not Waived	Not Waived
Major	Not Waived	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.	$1,500
Maximum rollover	Yes	Yes
Monthly Switch	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a percentage of fee schedule.)
Office Visit Co-pay (one office visit may cover	None	None

	Dental - DentalGuard Pref - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Syracuse** network will be most cost effective.	
	In Network	Out of Network
multiple services)		
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:	80%	80%
Fillings (one surface)	80%	80%
General Anesthesia[1]	80%	80%
Scaling & Root Planing (per quadrant)	80%	80%
Simple Extractions	80%	80%
Major Care:	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
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

Pediatric Essential Health Benefit Coverage Information

	Dental - DentalGuard Pref - Syracuse - Low	
	In Network	Out of Network
Calendar year deductible	$150, Each family member must satisfy their individual deductible amount.	$150, Each family member must satisfy their individual deductible amount.
Preventive	Waived	Not Waived
Basic	Not Waived	Not Waived
Major	Not Waived	Not Waived
Orthodontia	Not Waived	Not Waived
Individual Out of Pocket Maximum	$350	N/A
Family Out of Pocket Maximum	$700	N/A
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Diagnostic & Preventive Care:	70%	70%
Oral Exam	70%	70%
Cleaning	70%	70%
X-Rays	70%	70%
Sealants	70%	70%
Fluoride	70%	70%
Basic Care:	50%	50%
Anesthesia	50%	50%
Fillings	50%	50%

	Dental - DentalGuard Pref - Syracuse - Low	
	In Network	Out of Network
Oral Surgery	50%	50%
Major Care:	50%	50%
Periodontal Maintenance	50%	50%
Periodontal Services	50%	50%
Endodontics/Root Canal Treatment	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
Implants	50%	50%
Medically Necessary Orthodontia	50%	50%

General Exclusions

- Reasonable,member out-of-pocket max as determined by each state. This means that once the member has reached his or her out-of-pocket max, the pediatric dental essential health benefits will be paid at 100% for the remainder of the benefit year.

- No annual or lifetime maximums may be applied to the pediatric dental essential health benefits.

- Limitation on orthodontia, where covered, to medically necessary only.

- Medically necessary orthodontics includes, but may not be limited to, orthodontic treatment of skeletal, dental and/or occlusal conditions due to cleft palate and resulting in severe or handicapping malocclusion. Medically necessary orthodontics does not include orthodontic treatment performed solely for crowded dentitions (crooked teeth), excessive spacing between teeth, and/or having horizontal/vertical (overjet/overbite) discrepancies.

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.