



DentalGuard

DentalGuard Preferred PPO Plan

The DentalGuard Preferred PPO Plan is somewhat more expensive and offers less comprehensive benefits. It provides you the freedom to visit any dentist for services.

There are many advantages to the DentalGuard Preferred Option:

- Freedom to visit any licensed dentist.
- The DentalGuard Preferred network is the largest network Guardian offers in your area.
- Participation DentalGuard network dentists have agreed to a reduced fee schedule that is typically 35-45% less than what dentists usually charge. You benefit from these savings when you obtain care from a participating DentalGuard dentist because the participating dentist has agreed to accept these fees as payment in full.

How the DentalGuard Preferred (PPO) Network Plan Works:

When you need to make a dental appointment, you may choose a participating or non-participating dentist anytime during the year. When you receive services you or your dentist will submit a claim form to Guardian. Guardian will determine your benefits in general based on the following:

The Dentist is	A PPO Provider	Not a PPO Provider*
Services you received were...	Benefits to be provided are....	
Preventive (deductible does not apply to Preventive Services) Oral Exams, Teeth Cleaning, Florida Treatment	100%	80%
Basic Services Fillings, X-Ray, Topical Sealants	80%	80%
Major Services Endodontics, Oral Surgery, Periodontics	50%	50%
Major Services Acrylic, Gold & Porcelain Crowns, Installation & Repair of Bridgework and Dentures, Inlays, Onlays	50%	50%
Calendar Year Maximum	\$1000	
Calendar Year Deductible Maximum of three deductibles per family	\$50	\$75
Deferred Services	12 month wait on Periodontics and Major Restorative services	

Enrollment Deadline

- All Employees must complete the enclosed application, indicating whether you elect coverage under the DentalGuard Preferred Plan (PPO) plan, or decline coverage.
- Your Benefits Administrator will determine by when the applications must be completed.

*All benefits for services received from a non PPO provider are based on Usual, customary and reasonable rates for a given area. For Basic and Major services, the deductible must be met prior to plan benefit payment. Once the annual plan maximum has been reached, no more benefits will be available until the beginning of the next plan year.



DentalGuard Preferred PPO option

DentalGuard Preferred PPO

\$1000 maximum

\$50 deductible in network waived for preventive

\$75 deductible out of network waived for preventive

Out of network covered at 70% Reasonable & Customary

Deferred Crowns, Bridges, Prosthodontics & Periodontics for all employees for 12 months

<i>Sample Covered Charges</i>		<i>In Network</i>	<i>Out of Network</i>
Code	Name		
Diagnostic and Preventive			
0120	Periodic Examination	100%	80%
1110	Prophylaxis-adult(teeth cleaning)	100%	80%
0210	Full mouth x-rays	80%	80%
Restorative			
<i>Fillings (amalgam)</i>			
2140	One surface-permanent	80%	80%
2151	Two surfaces-permanent	80%	80%
2160	Three surfaces-permanent	80%	80%
Endodontics			
<i>Root Canal therapy</i>			
3310	Anterior	50%	50%
3320	Bicuspid	50%	50%
3330	Molar	50%	50%
Periodontics			
4341	Perio scaling & root planing, per quadrant	50%	50%
4210	Gingivectomy, per quadrant	50%	50%
4211	Gingivectomy, per tooth, up to 2 teeth	50%	50%
Crown and Bridge			
2740	Porcelain Crown	50%	50%
2750-52	Porcelain with metal crown**	50%	50%
2790-92	Cast Metal Crown**	50%	50%
Prosthodontics			
5110-20	Complete denture (upper or lower)	50%	50%
5213	Partial denture	50%	50%
5731	Denture reline (chairside)	50%	50%
5730	Denture reline (laboratory)	50%	50%
Oral Surgery			
7110	Extract single tooth	50%	50%
7510	Incision and drainage of abscess	50%	50%
Impactions			
7220	Extract impacted tooth, soft tissue	50%	50%
7230	Extract impacted tooth, partial bony	50%	50%
7240	Extract impacted tooth, full bony	50%	50%
Orthodontia-Comprehensive Treatment*			
	Child to age 18		not covered
	Member over age 18		not covered

*The copay listed is for banding only. See the Ortho Schedule of Benefits for a complete listing of all services and copays.

** If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

DentalGuard Dental Insurance Plan General Limitations & Exclusions: this policy provides dental insurance only. Coverage is limited to those 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), orthodontic (unless expressly provided for), cosmetic or experimental 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. GP-1-DG2000 et al.

Questions and Answers

The Guardian's Voluntary DentalGuard Preferred Program PPO Plan

What is Guardian's Voluntary DentalGuard Insurance?

An opportunity to help protect and care for your smile — and your family's — at affordable group rates. You pay plan premiums through convenient payroll deduction.

Can I visit any dentist or specialist or only certain ones?

If you go to a DentalGuard Preferred Network Provider, the benefits described on the Benefit and Cost Summary will be paid based on a reduced fee schedule (this will mean less out-of-pocket). The network provider cannot balance bill charges in excess of the fee schedule and you get more services with your yearly maximum. If you go to a non-contracted dentist, the benefits will be based on usual, customary and reasonable rates for a given area.

What is a plan deductible and/or annual maximum?

A *deductible* is the dollar amount of covered dental expenses you must pay during the year before benefits are paid by The Guardian. An *annual maximum* is the maximum amount your dental plan will pay in benefits during the year. Both are generally based on the calendar year. Deductibles and annual maximums apply to each covered person.

What is co-insurance?

For some service categories, you may share in the cost of your dental expenses. This is represented as a percentage of the usual, customary, and reasonable level (if a non-network dentist is used) *or* a percentage of the negotiated fee for covered services (if a network dentist is used). The percentage of co-insurance usually depends on the type of service received: Preventive, Basic or Major. Network services are typically reimbursed at a higher co-insurance percentage.

What is a negotiated fee-for-service?

This refers to the set maximum fees for services that have been negotiated with our contracted network dentists and specialists. These average 30% less than the fees they usually charge.

What is pre-treatment review?

For all courses of treatment expected to exceed \$300, your dentist should submit a report to The Guardian describing the proposed treatment and itemizing expected charges. We will review the report and send the dentist an estimate of benefits we will pay. This will help ensure that you receive the best and most appropriate treatment necessary. Emergency treatment, oral examinations, cleaning, and x-rays may be performed before the review is prepared.

When I visit a dentist, are there any claim forms to fill out?

Network dentists have contracted with The Guardian to submit claim forms and accept benefits directly from The Guardian.

Some non-network dentists may submit claims directly to The Guardian. More often, however, non-network dentists will require that you pay for services at the time they are rendered. Afterwards, complete a simple claim form and forward it to us along with a copy of your payment receipt.



GUARDIAN®

The Guardian Life Insurance Company of America, New York, NY

Questions and Answers

How can I find a network dentist or specialist near me?

You may either refer to your DentalGuard Preferred provider directory or locate a dentist on the Internet using our on-line listing at www.glic.com.

Do all my covered family members have to go to the same network or non-network dentists?

No. In fact, if they wanted to, every family member could go to a different network or non-network dentist or specialist, every time they need care.

What does usual, customary, and reasonable mean?

Usual, customary, and reasonable (UCR) charges for covered services are determined by using the usual level of charges made by the majority of dentists in the same geographic area for the same service. If your dentist's fee is lower than the UCR charge, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based only on the UCR charge, and you are responsible for any amount above the UCR limit.

When will my coverage go into effect?

Your benefits coordinator will notify you when your coverage takes effect.

Important Information about Your Dental Plan

Finding a Network Dentist

To find a dentist that participates in our network you may access our on-line provider directory on our website at www.GuardianLife.com.

Prior to seeking treatment, please verify with your dentist that he/she participates in our network.

DentalGuard Preferred Network: For additional information on the status of the dentists, as well as new dentists, please call 800-890-4774 from 9am to 7:30pm – Eastern Time.

Late Entrants to the DentalGuard Preferred PPO Plan

If A Late entrant is an employee or dependent who does not enroll in the plan within the 31 days after becoming eligible or during the annual open enrollment period. Upon enrollment, a late entrant is subject to substantial waiting periods before non-preventive services will be covered.

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GUARDIAN®

The Guardian Life Insurance Company of America, New York, NY

Pub 2682B (4/97)

Log 96-1954

<p><i>Guardian Dental</i> Enrollment Worksheet</p>

(Renewal Date 10/31/08)

PPO Plan	Single	\$ 53.00
	Couple	\$ 88.00
	Family	\$124.00

Dental Premium: \$ _____

One Time Enrollment Fee: \$ **40.00**

Total Contribution at Enrollment: \$ _____

- Make One Check Payable to I.R.G (Local 831 NY Administrator)
- The Above Rates include Union Dues
- Monthly billing is Only done threw electronic funds transfer (EFT)
- Applicant must complete Billing form
- Applications must received by 20th of the month prior to the start

Mail To:
 Martin Unger
 5070 NW 96th Way
 Coral Springs, Fl 33076

Member Name _____

Date _____

Member Signature _____

The Guardian Life Insurance Company of America

Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

GG-013499NY Enrollment Form For Non-Medical Coverages

Planholder Name (Company Name) Local 831 National Allied Workers Union		Group Plan No.	Division	Class
Planholder Street Address 20 Madison Avenue		City Valhalla	State NY	Zip 10595
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced				
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE DATE OF CHANGE ___/___/___ REASON FOR CHANGE _____				
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED				
Name (Last, First, Middle Initial)		Social Security #	Sex	Birthdate
Employee:			<input type="checkbox"/> M <input type="checkbox"/> F	
Spouse:			<input type="checkbox"/> M <input type="checkbox"/> F	Date of Marriage / /
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement:				
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s): _____ Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Full Time Employment	Hrs. Worked / Week	Occupation /Job Title		
Employee's Street Address		City		
State	Zip	Business Phone #	Home Phone #	
DENTAL				
<input type="checkbox"/> I elect PPO Plan.		SPOUSE: <input type="checkbox"/> Yes <input type="checkbox"/> No ***		CHILD(REN): <input type="checkbox"/> Yes <input type="checkbox"/> No ***
<input type="checkbox"/> I elect MDG Plan.		Spouse's Dental Office # _____		Child(ren)'s Dental Office # _____
<input type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **				
** If declining coverage, are you covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
*** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DECLINATION OF COVERAGE:				
If I have waived the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.				
<ul style="list-style-type: none"> I hereby apply for the group benefit(s) indicated above. I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex. I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance. The information provided above is true and correct to the best of my knowledge. Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. 				
X SIGNATURE OF EMPLOYEE				DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN

CEF-1999

Billing Application

Requested effective date (mm/dd/year)

___/___/___

Billing Information – Invoices should be sent to:

Contact Person

Title

Company Name

Address

City

State

Zip Code

Telephone

Fax

Broker: Lisa Unger - LU5460

Payment Options:

Direct Withdrawal (See attached authorization form below)

Monthly Invoice (\$10 Billing Fee)

Please Note there is a \$30 Bounce Fee

EFT AUTHORIZATION

Bank Route Code# _____ Bank Account# _____

Please deduct payment of \$ _____ between the 15th & 20th of the month **Prior** to the next months coverage.

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to **I.R.G.** three (3) business days or more before this payment is scheduled to be made. **Please be aware that your bank statement will reflect the debit as I.R.G-HEALTH & there will also be a \$5 Charge a month for EFT.**

Signature of Depositor  _____

Date: _____

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY