



Summary Plan Description

Full-Time Actives





Dental (Full-Time Actives)

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Coverage is provided to plan participants and eligible dependents through either the Guardian Life Insurance Company or Delta Dental. Plan participants are required to select one of the options for themselves and their families. Those who do not make an election are automatically enrolled in the Guardian program. Both the Guardian program and the Delta program are available to eligible members at no payroll deduction. Neither has a “rider” option.

Guardian Dental Guard Preferred



[Guardian Fee Schedule](#)

This is a “preferred provider” (PPO) program with two components:

1. Access to a panel of [dental providers](#) who charge reduced fees
2. A higher Welfare Fund rate paid to participating dentists (according to the Guardian Fee Schedule)

Benefits include most standard dental procedures. There are no annual or lifetime maximum payment limitations. Plan participants may use any licensed dentist to provide services, although non-participating dentists are not required to charge the reduced fees, thereby reducing the value of the benefit. Also, non-participating dentists are not eligible for the higher Welfare Fund rate paid to participating dentists.

The provider panel maintained by Guardian Life is Dental Guard Preferred. Your Group Plan Number is 381084.

Information on participating dentists is available from Guardian on their [website](#) or by phone (1-800-848-4567).

Frequency Limits: Standard prophylactic care (cleaning and necessary x-rays) is covered once every four months.

For Guardian EOBs You Must Register Online

Guardian will no longer issue EOBs by U.S. mail. In response to the coronavirus, Guardian is working to minimize service disruption that could include longer wait times and delays. In addition, the explanation of benefits (EOB) on dental claims will now be delivered electronically using Guardian Anytime.

Registering is easy

1. Go to the [self-registration page](#) and choose Member as your User Role. Please note, for Dependent User Role registration, you will need the Member's Group ID Number, 381084, and Social Security Number.
 2. Fill in your member information and Group ID Number, 381084.
 3. Create a username and password, click Submit, and you're done.
- Already registered? [Log in to your account](#) anytime.

Services available to you on Guardian Anytime

- Submit claims and track status including receiving email alerts when dental claims are paid
- View EOB for all of your dental services
- View your summary of benefits
- Find dental cost estimates and educational information
- Check status of evidence of insurability
- Print dental ID card
- Access forms and materials related to your coverage

Pre-Treatment Review

Each plan participant is entitled to be informed by Guardian of the total cost, plan reimbursement and out-of-pocket costs associated with a course of dental treatment. Forms are available at participating dentist offices or from Guardian. Pre-treatment review is recommended.

How do I file an out-of-network dental claim?

Claim forms are available on the [Forms page](#) or from participating providers, by mail from Guardian and through the Guardian Website. Guardian Forms have the mailing address on them. Claim forms should be submitted to:

Guardian Group Dental Claims P.O. Box 981572 El Paso, TX 79998-1572

What is not covered by my Guardian Dental Plan?

Coverage is not provided for certain types of care. [Treatment exclusions](#) often involve technical matters. There are also [procedural limitations](#) by frequency or age.

DeltaCare USA



This is a dental Health Maintenance Organization. DeltaCare USA will assign a primary care dentist for members upon enrollment. (Once enrolled, you have the opportunity to switch to another participating Delta dentist by calling 800-422-4234.) That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with a [copay schedule](#) that Delta has negotiated with the dentists. The patient fee is set for each service.

Unlike traditional insurance, there are no claims to complete or reimbursement to await. There is no annual or lifetime limit on services.

Enrollment in the Delta program is available each year and coincides with the City-wide open enrollment period.

The HMO program is sponsored by Delta Dental and called DeltaCare USA. It is administered by:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579

Information on dentists participating with the HMO is available from Delta on their [website](#) (Select network for DeltaCare USA) or by phone (1-800-422-4234).

Please be aware that most participating Delta dentists are located in New York and New Jersey. For availability of Delta dentists outside those areas, call Delta or check the Delta website.

Optional Fee Payments

Certain procedures are deemed “optional” in the Delta Fee list which typically indicates that it is a procedure that may exceed an accepted norm of service. For example, color-matched fillings are above the norm on molars, whereas they are standard practice on front teeth. Members who decide to have color-matched fillings on molars would pay a higher fee and that fee is in accordance with the profile of each dentist maintained by Delta dental. PMI Dental Health can provide this information.

Emergency Care

Whereas members are generally required to use the primary dentist, or an HMO specialist referred by that dentist, there is a provision for emergency treatment up to \$100 per year. Claim forms and regulations are available from PMI Dental Health at the address listed above.

Exclusions and Limitations

Coverage is not provided for certain types of care. Be sure to review the [limitations and exclusions](#) for both standard benefits and orthodontic benefits.

Appendix

Guardian Dental General Treatment Exclusions from Coverage (scroll down for Delta Exclusions & Limitations)



- Purely cosmetic treatment
- More than one prophylactic visit every 4 months
- Temporomandibular joint (TMJ) dysfunction
- Replacement of stolen or lost appliances
- Services that do not meet commonly acceptable dental standards
- Services covered under Basic Health Insurance
- Any service or supply not included on Guardians List of Covered Services
- Procedures related to or performed in conjunction with non-covered work
- Educational, instructional or counseling services
- Precision attachments, magnetic retention or overdenture attachments
- Replacement of a part of above
- Services related to overdentures e.g., root canal therapy on supporting teeth

- General anesthesia or sedation, except inhalation sedation related to periodontal surgery, surgical extractions, apicoectomies, root amputations or certain other oral surgical procedures
- Local anesthetic, except as part of procedure
- Restoration, procedure, appliance or device used solely to alter vertical dimension, restore or maintain occlusion, treat a condition resulting from attrition or abrasion or splint or stabilize teeth for periodontal reasons
- Cephalometric radiographs or oral/facial imaging
- Fabrication of spare appliances
- Prescription medication
- De-sensitizing medicaments or resins
- Pulp viability or caries susceptibility testing
- Bite registration or analysis
- Gingival curettage
- Localized delivery of chemotherapeutic agents
- Maxillofacial prosthetics
- Temporary dental prosthesis or appliances except interim partials to replace anterior teeth extracted while covered
- Replacing an existing appliance, except when it is over 10 years old and deemed unusable or it is damaged by injury while covered and not reparable.
- A fixed bridge replacing the extracted portion of a hemisected tooth
- Replacement of one or more unit of crown and/or bridge per tooth
- Replacement of extracted / missing third molars
- Treatment of congenital or developmental malformations
- Endodontic, periodontal, crown or bridge abutment procedure or appliance related to tooth with guarded or worse prognosis
- Treatment for work-related injury
- Treatment for which no charge is made
- Detailed or extensive oral evaluations
- Evaluations and consultations for non-covered services

1. Three Prophylaxes (1110 or 1120) or Periodontal Maintenance Treatments (4910) per calendar year.
2. Two Fluoride Treatments (1201 or 1203 or 1205), limited to under age 14, per calendar year.
3. One Unilateral Space Maintainer (1510 or 1520), limited to under age 16 and replacing lost/extracted deciduous teeth, per arch per lifetime.
4. One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted deciduous teeth, per arch per lifetime.
5. One Emergency Palliative Treatment (9110) in any 6-month period.
6. One Full-Mouth Series or Panoramic Film (0210 or 0330) in any 60 consecutive month period.
7. One Sealant Treatment to Permanent Molar (1351), limited to under age 16 on unrestored tooth, per tooth in any 36 consecutive month period.
8. One Diagnostic Consultation by Non-treating Dentist (9310) per dental specialty in any 12 consecutive month period.
9. Appliance to Control Harmful Habits (8220) limited to under age 14.
10. Replacement of Amalgam Restoration (2110 through 2161) only after 12 or more months since prior procedure, if under age 19.
11. Replacement of Amalgam Restoration (2110 through 2161) only after 36 or more months since prior procedure, if age 19 or older.
12. Replacement of Resin Restoration (2330 through 2388) only after 12 or more months since prior procedure, if under age 19.
13. Replacement of Resin Restoration (2330 through 2388) only after 36 or more months since prior procedure, if age 19 or older.
14. One Crown (2336 or 2337 or 2710 or 2930 – 2933) per tooth in any 24 consecutive month period.
15. Recement Bridge (6930) only after 12 or more months since initial insertion.
16. One Denture Rebase (5710 or 5711 or 5720 or 5721) per 24 consecutive month period and only 12 or more months after insertion.
17. One Denture Reline (5730 through 5761) per 24 consecutive month period and only 12 or more months after insertion.
18. One Denture Adjustment (5410 or 5411 or 5421 or 5422) in any 24 consecutive month period.
19. One Tissue Conditioning (5850 or 5851) per arch per 12 consecutive month period and only 12 or more months after denture insertion.

20. One Periodontal Root Planing (4341), with evidence of bone loss, per quadrant in any 24 consecutive month period.
21. One Periodontal Scaling (4341), in the absence of related work in prior 36 months, per quadrant in any 36 consecutive month period.
22. One Distal or Proximal Wedge (4274), with evidence of periodontal disease of each tooth, per quadrant per 36 consecutive month period.
23. One Gingivectomy or Crown Lengthen (4211 or 4249), with evidence of periodontal disease of each tooth, per 12 consecutive month period.
24. One Soft Tissue Graft or Subepithelial Connective Tissue Graft (4270 or 4271 or 4273), per quadrant in any 36 consecutive month period.
25. One Bone Graft or Guided Tissue Regeneration (4263 or 4266 or 4267) per tooth or area, in a lifetime period.
26. Two visits for Occlusal Adjustment (9951 or 9952), with appropriate evidence, in any 6 month period after scaling / root planing / osseous surgery.

Guardian Dental Program Limitations by Best Practice or Cosmetic Determinants



1. Labial Veneers are covered only for decay or injury to permanent tooth that cannot be restored with amalgam or composite filling
2. Resin Restoration (2330 through 2388) limited to anterior teeth. Resin Restoration to posterior teeth is reimbursed at amalgam rates.
3. Specialized techniques and characterizations for Bridge Abutments, Crown (6791 or 6792) are not covered.
4. Crowns (2720 through 2792), Buildups(2950), Inlays/Onlays (2510 through 2664) and Core Buildups for Retainer (6973) only with decay or injury when the tooth cannot be restored with amalgam or composite filling material. Permanent teeth only.
5. Cast Post and Cores (2952 through 2972) only with decay or injury, when done in conjunction with a covered unit of crown or bridge and when needed substantial loss of tooth structure. Permanent teeth only.

Delta Dental HMO Standard Benefit Limitations



1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. A full mouth x ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant;
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
12. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist's usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment;
13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment;
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to

cuspid) and facial surfaces of maxillary bicuspid;

15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, nonfunctional bridge and it meets the five year limitation for replacement;

16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;

17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;

18. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment;

19. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's filed fees for the covered procedure and Optional treatment, plus any Copayment for the covered procedure

Delta Dental HMO – Standard Benefit Exclusions



1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;

2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;

3. Treatment required by reason of war, declared or undeclared;

4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;

5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of

TMJ abnormalities which are medical in nature;

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);

7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;

8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;

9. Cysts and malignancies which are medical in nature;

10. Prescription drugs;

11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;

12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;

13. Prophylactic removal of impactions (asymptomatic, nonpathological);

14. "Consultations" for noncovered procedures;

15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;

17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL

OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;

18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations



1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;
4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with

the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;

8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;

9. Cysts and malignancies which are medical in nature;

10. Prescription drugs;

11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;

12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;

13. Prophylactic removal of impactions (asymptomatic, nonpathological);

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16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;

17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;

18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;

19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations



The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in the Description of Benefits and Co-payments (Schedule A) subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist;
2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months;
3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed \$75 per month;
4. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;
5. Three re-cementations or replacements of a bracket/band on the same tooth or a total of five re-bracketings /re-bandings on different teeth during the covered course of treatment are benefits. If any additional re-cementations or

replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the contract orthodontist's usual fee;

6. The Co-payment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Co-payment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment;

Delta Dental HMO – Orthodontic Benefit Exclusions



1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Re-treatment of orthodontic cases;
3. Surgical procedures incidental to orthodontic treatment;
4. Myofunctional therapy;
5. Surgical procedures which are medical in nature related to cleft palate, micrognathia, or macrognathia;
6. Treatment related to temporomandibular joint disturbances which are medical in nature;
7. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;
8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed \$75 per month;
9. Restorative work caused by orthodontic treatment;
10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;
12. Treatment in progress at inception of eligibility;
13. Patient initiated transfer after bands have been placed;
14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

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Have Questions?

Guardian

800-848-4567

[Website](#)

Delta Dental

800-422-4234

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