



Summary of Benefits

Dental Benefit Summary

Group ID:	00067234	Coverage Type:	Contributory
Group Name:	MERION RESIDENTIAL	Class:	0002 MAINLINE
Waiting Period:	1st of the month following 60 day(s)	As of Date:	06/01/2026

Plan Information

Your dental networks are: Dental - DentalGuard Pref and Dental - DentalGuard Pref

Coverage Information

What's the most cost-effective way to use dental insurance?	Dental - DentalGuard Pref		Dental - DentalGuard Pref	
	With your PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.		With your PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.	
	In Network	Out of Network	In Network	Out of Network
Calendar year deductible	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	Out of Network is a combined deductible for in and out of network services.	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive	Waived	Waived		Waived
Basic	Not Waived	Not Waived		Not Waived
Major	Not Waived	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.	\$2,000	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	\$2,000
Lifetime Orthodontia Maximum	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	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	Yes	Yes	Yes	Yes
Monthly Switch	Not Available	Not Available	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a percentage of fee schedule.)	How much does the plan pay?	How much does the plan pay?
Office Visit Co-pay (one office visit may cover multiple services)	None	None	None	None
Preventive Care:	100%	100%	100%	100%
Bitewing X-Rays	100%	100%	100%	100%
Full Mouth X-Rays	100%	100%	100%	100%
Cleaning	100%	100%	100%	100%
Oral Exams	100%	100%	100%	100%

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	In Network	Out of Network	In Network	Out of Network
Sealants (per tooth)	100%	100%	100%	100%
Basic Care:	100%	100%	80%	80%
Fillings (one surface)	100%	100%	80%	80%
General Anesthesia ¹	100%	100%	80%	80%
Scaling & Root Planing (per quadrant)	100%	100%	80%	80%
Simple Extractions	100%	100%	80%	80%
Major Care:	60%	60%	50%	50%
Dentures	60%	60%	50%	50%
Single Crowns	60%	60%	50%	50%
Orthodontia	50%	50%	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.

 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.