

Dental Plans

COMPARE YOUR PLANS

Option 1: With your **Network Access Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Option 2: With your **Value Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

COMPARE THE PLANS	Option 1: Network Access		Option 2: Value Plan	
Your Monthly premium	\$0.00		\$0.00	
You and spouse	\$26.78		\$26.78	
You and child(ren)	\$32.19		\$32.19	
You, spouse and child(ren)	\$58.96		\$58.96	
Calendar year deductible	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Individual	\$50	\$50	\$0	\$0
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care (e.g. cleanings)	100%	100%	100%	100%
Basic Care (e.g. fillings)	80%	80%	100%	100%
Major Care (e.g. crowns, dentures)	50%	50%	60%	60%
Orthodontia	Not Covered		Not Covered	
Annual Maximum Benefit	\$1000	\$1000	\$1000	\$1000
Maximum Rollover	Yes		Yes	
Rollover Threshold	\$500		\$500	
Rollover Amount	\$250		\$250	
Rollover In-network Amount	\$350		\$350	
Rollover Account Limit	\$1000		\$1000	
Lifetime Orthodontia Maximum	Not Applicable		Not Applicable	
Network	DentalGuard Preferred		DentalGuard Preferred	

YOUR GUARDIAN PLAN OFFERS:

Family coverage for spouse and children to age 25 (26 if full-time student)

No charge for preventive care (subject to plan limits)

Maximum rollover If a member submits at least one claim and stays under the claims threshold, a part of the unused maximum will be rolled over for use in future years.

National PPO network of more than 70,000 dentist locations

Reliable claims payment four days on average

Find out if your dentist is in Guardian's network at www.guardianlife.com

CATEGORY	PLAN DETAILS	Option 1: Network Access		Option 2: Value Plan	
		Plan pays (on average)		Plan pays (on average)	
		In-network	Out-of-network	In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	No Age Limits		No Age Limits	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia	80%	80%	100%	100%
	Fillings (one surface)	80%	80%	100%	100%
	Perio Surgery	80%	80%	100%	100%
	Periodontal Maintenance	80%	80%	100%	100%
	Frequency:	Once Every 3 Months (Enhanced)		Once Every 3 Months (Enhanced)	
	Root Canal	80%	80%	100%	100%
	Scaling & Root Planing (per quadrant)	80%	80%	100%	100%
	Simple Extractions	80%	80%	100%	100%
Major Care	Bridges and Dentures	50%	50%	60%	60%
	Dental Implants	Not Covered	Not Covered	60%	60%
	Inlays, Onlays, Veneers**	50%	50%	60%	60%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%	60%	60%
	Single Crowns	50%	50%	60%	60%
	Surgical Extractions	50%	50%	60%	60%

Please note: The plan details listed here are some of the most common services related to dental coverage. The co-insurance percentages for the PPO plan options correspond to the coverage categories of Preventive, Basic, Major and Orthodontia listed in the table above.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury and only when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age of 19; full-time student age does not apply to the initial placement of the appliance. Orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period (^Additional cleanings are available for an additional co-pay).

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: 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), orthodontia (unless expressly provided for), cosmetic or experimental treatments, 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. Residents of Illinois - Dependent age limits 26/26. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
- **Special Limitation:** 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



Employer:
Ozarks Technical Community College
1001 E Chestnut Expy
Springfield, MO 65802

Guardian Group Plan Number: **443224**
 Plan Administrator: **Alice Ramey**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / /			
Class All Eligible Employees	Hours Worked	Division	Benefits Effective / /
Keep a copy for your records and return form to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012			

ABOUT YOURSELF <i>Print clearly in black or blue ink.</i>			
First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -
Address	City	State	Zip
Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ABOUT YOUR DEPENDENTS <input type="checkbox"/> A sheet with information about additional dependents is attached.					
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date / /	
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages. <input type="checkbox"/> Dental					

CHOOSE YOUR DENTAL COVERAGE*Check one box only*

Your monthly premium	Option 1: Network Access Plan	Option 2: Value Plan		
Employee alone	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00		
Employee and Spouse	<input type="checkbox"/> \$26.78	<input type="checkbox"/> \$26.78		
Employee and Child(ren)	<input type="checkbox"/> \$32.19	<input type="checkbox"/> \$32.19		
Entire family	<input type="checkbox"/> \$58.96	<input type="checkbox"/> \$58.96		

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Termination or Expiration of coverage	Date of coverage loss / /
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IMPORTANT NOTES

- **Newborn Children:** A newborn child will be covered for the first 31 days from the moment of his or her birth. To continue coverage beyond the first 31 days, you must notify Guardian within 31 days of the newborn child's date of birth. Guardian will then provide any necessary forms and instructions for enrollment. You must enroll the child and agree to make any additional required payments, within 10 days of receipt of the forms. If you fail to do this, the newborn child's coverage will cease at the end of the first 31 days. If you later enroll the child, he or she will be considered a late enrollee
- **Proof of insurability** does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **I attest that 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.**

SIGNATURE OF EMPLOYEE **X**

DATE