



## Summary of Benefits

### Dental Benefit Summary

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Group ID:	00438079	Coverage Type:	Voluntary
Group Name:	CITY OF NEWTON	Class:	0001 ALL QUALIFIED CITY OF NEWTON RETIREES
Waiting Period:	None	As of Date:	04/07/2021

### Plan Information

Your dental networks is: Dental - DentalGuard Pref NAP - Massachusetts

### Coverage Information

#### Dental - DentalGuard Pref NAP - Massachusetts

**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 NAP - Massachusetts** network will be most cost effective.

	In Network	Out of Network
<b>Calendar year deductible</b>	Out of Network is a combined deductible for in and out of network services.	\$25, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive		Waived
Basic		Not Waived
Major		Not Waived
<b>Calendar Year Maximum Benefit</b>	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	\$1,000
<b>Maximum rollover</b>	Yes	Yes
<b>Monthly Switch</b>	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?
<b>Office Visit Co-pay (one</b>	None	None

## Dental - DentalGuard Pref NAP - Massachusetts

**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 NAP - Massachusetts** network will be most cost effective.

	In Network	Out of Network
<b>office visit may cover multiple services)</b>		
<b>Preventive Care:</b>	90%	90%
Bitewing X-Rays	90%	90%
Full Mouth X-Rays	90%	90%
Cleaning	90%	90%
Oral Exams	90%	90%
Sealants (per tooth)	90%	90%
<b>Basic Care:</b>	50%	50%
Fillings (one surface)	50%	50%
General Anesthesia <sup>1</sup>	50%	50%
Scaling & Root Planing (per quadrant)	50%	50%
Simple Extractions	50%	50%
<b>Major Care:</b>	40%	40%
Dentures	40%	40%
Single Crowns	40%	40%
<b>Orthodontia</b>	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.

 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.



## Summary of Benefits

### Vision Benefit Summary

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Group ID:	00438079	Coverage Type:	Contributory
Group Name:	CITY OF NEWTON	Class:	0001 ALL QUALIFIED CITY OF NEWTON RETIREES
Waiting Period:	None	As of Date:	04/07/2021

### Plan Information

### Coverage Information

**What's the most cost-effective way to use vision benefits?**

#### Co-Pay

First service provided

Exams

Materials

**How often can I obtain service?**

#### Eye exams

#### Lenses

Single vision lenses

Lined bifocal lenses

Lined trifocal lenses

Lenticular lenses

#### Contact Lenses

## What's the most cost-effective way to use vision benefits?

Conventional

Planned replacement

Medically necessary

Evaluation and fitting

### Frames

#### Lens & Frame Allowance

#### Cosmetic Extras

#### Laser correction surgery

#### Hearing

## Vision and General Exclusions

### Important information

This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for:

- Orthoptics or vision training and any associated supplemental testing;
- Medical or surgical treatment of the eye;
- Eye examination or corrective eyewear required by an employer as a condition of employment;
- Replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists).

The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. 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-VSN-96-VIS et al.

### Laser Correction Surgery

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.



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