CMU CENTRAL MICHIGAN UNIVERSITY | Human Resources Benefits & Wellness

Guardian Dental Plan
Frequently Asked Questions

Guardian

When does my coverage with Guardian dental begin?
The new Guardian dental plan is effective July 1, 2019. Any claims incurred prior to July 1, 2019 should be filed with the previous dental claims administrator, Meritain Health. If you are in the middle of having work done that requires multiple appointments, such as a root canal, the previous claims administrator will be responsible for processing the claim, even if the treatment extends past July 1.

What is the plan name and policy number?
Depending on which plan you elected during Open Enrollment, the plan name is either Core plan (formally referred to as 100-50-50) or Buy-Up plan (or 100-75-50-50). The group policy number is 560625.

Will I receive an identification care for Guardian dental?
Yes. If you elected dental coverage for the 2019-20 plan year, you will receive a new ID card(s) in the mail in the middle of June 2019. On or after July 1, you can also go online and print a card. The web address is www.GuardianAnytime.com.

Where can I find a benefits summary of the Guardian dental plans.
The benefits summary can be found on the Open Enrollment page at www.cmich.edu/openenrollment.

Do I have to use a Guardian dental provider to get covered benefits?
No. You can visit any licensed dentist, anywhere. Guardian has a strong provider network with over 91,000 dentists who accept Guardian coverage. Your out-of-pocket may be lower if you use a dentist in Guardian's dental network and you are not responsible for charges above negotiated fees.

How do I find an in-network Guardian dental provider?
Visit www.GuardianAnytime.com. Click on "Find a Provider" link at the top of the page and then the "Search Provider" button. Under the "Plan Type" select "PPO". Complete the details of your search (e.g. zip code, dentist last name, office name) and click on the "Search" button.

My dentist is not a participating provider in the Guardian dental network. How will my out-of-network claim be paid?
Out-of-network providers are paid 100% of participating provider benefit. Guardian has negotiated rates with in-network providers. When a provider joins the Guardian dental network, h/she agrees to accept the negotiated rate as payment for services. For example, if the negotiated rate for a cleaning is $75, the in-network provider agrees to accept this amount as full payment for the service, even if the provider normally charges $100 for the service.

If you have a cleaning performed by an out-of-network provider, Guardian will pay $75, or 100% of the participating provider negotiated rate for the service. If the out-of-network provider charges $100 for this service, s/he may bill you the difference of $25 and you will have to pay that amount out-of-pocket.

I have a second dental insurance plan. Can I collect full benefits from both plans?
You cannot collect full benefits from each plan. Coordination of benefits will apply. The maximum you can collect between the two plans cannot exceed the cost of the service. The insurance companies will determine which plan is primary (pays first) and which is secondary (pays after the primary carrier has paid).

Is pre-authorization required for services?

Pre-authorization is when the dentist submits a plan for services to the dental provider in order to get an idea, before the work is done, of how much the insurance plan will pay. It's not required, but can be a good idea if major and/or expensive services are needed.

Is there a maximum annual benefit? What is the plan year?

For the Core plan, the annual plan maximum per covered individual is $1,000. For the Buy-Up plan, the annual plan maximum per covered individual is $1,500. The maximum applies to basic and major care services. There is also an orthodontia lifetime maximum of $2,000 per covered child in the Buy-Up plan.

The plan year for the deductible and annual plan maximum is July 1 through June 30.

What is the annual deductible on the Core plan and how does it work?

The annual deductible applies to basic and major care services. In a single person policy (or employee only coverage), one person has to reach a $50.00 deductible before benefits are paid on basic and major services. Each person in a two-person policy (or employee + one dependent) must reach a $50.00 deductible before benefits are paid. With a family policy (or employee + 2 or more dependents), the $150.00 family deductible may be reached by summing the deductible amounts paid by each family member up to the $150.00 maximum amount. No one person contributes more than $50.00 towards the deductible.

Are the requirements for my employed spouse to be eligible as a dependent in the dental plan of CMU CHOICES the same as for the medical coverage?

Yes. Your spouse / Other Eligible Individual (OEI) must elect to take their employer sponsored dental coverage through his/her place of employment if he or she is eligible, and the employer makes a contribution toward coverage costs. However, CMU CHOICES may serve as a secondary source for a working spouse / OEI, (through two-person or family coverage). Further details are available on the Working Spouse / OEI Rule FAQ webpage.