

Dental Benefit Summary

Group Number: 00441291

A Dental insurance plan through Guardian:

- Provides coverage for key preventive services such as regular checkups and cleanings to keep you and your family healthy
- Helps offset potentially expensive dental procedures, such as crowns and fillings
- Gives you access to one of the nation's largest dental networks so care is convenient to you
- Makes it easy to find a high quality certified network dentist by accessing guardiananytime.com or Guardian's find a provider mobile app
- Fast and easy claim payments

About Your Benefits:

Option 1: Managed Dental Care plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.

Option 2: 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.

Your Dental Plan	Option 1: Managed Dental Care	Option 2: PPO	
Your Network is	Managed Dental Care	DentalGuard Preferred	
Calendar year deductible		<i>In-Network</i>	<i>Out-of-Network</i>
Individual	No deductible	\$50	\$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	<i>Network only</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	You pay a copay for each covered procedure. See "Plan Details", for more information.	100%	80%
Basic Care		80%	70%
Major Care		50%	40%
Orthodontia		50%	50%
Annual Maximum Benefit		\$1500	\$1000
		Combined In-Network and Out-of-Network maximum of \$1000 with an additional \$500 of benefit In-Network	
Maximum Rollover	Maximum Rollover is not applicable for this plan type.	Yes	
Rollover Threshold		\$500	
Rollover Amount		\$250	
Rollover In-network Amount		\$350	
Rollover Account Limit		\$1000	
Lifetime Orthodontia Maximum	Not Applicable	\$1000	
Office visit copay	\$0	None	
Dependent Age Limits	26	26	

A Sample of Services Covered by Your Plan:

		Option 1: Managed Dental Care You Pay	Option 2: PPO Plan pays (on average)	
		Network only	In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	\$0	100%	80%
	Frequency:	2 in 12 months	Once Every 6 Months	
	Fluoride Treatments	\$0	100%	80%
	Limits:	Under Age 18	No Age Limits	
	Oral Exams	\$0	100%	80%
	Periodontal Maintenance	\$20	100%	80%
	Frequency:	Once every 3 to 6 months (Standard)	Once Every 3 Months	
	Sealants (per tooth)	\$5	100%	80%
	X-rays	\$0	100%	80%
Basic Care	Anesthesia*	Not Covered	80%	70%
	Fillings‡	\$5	80%	70%
	Perio Surgery	\$235	80%	70%
	Repair & Maintenance of Crowns, Bridges & Dentures	\$25-40	80%	70%
	Root Canal	\$80-175	80%	70%
	Scaling & Root Planing (per quadrant)	\$40	80%	70%
	Simple Extractions	\$5	80%	70%
	Surgical Extractions	\$50-80	80%	70%
Major Care	Bridges and Dentures	\$220-255	50%	40%
	Dental Implants	Not Covered	50%	40%
	Inlays, Onlays, Veneers**	\$80-155	50%	40%
	Single Crowns	\$180	50%	40%
Orthodontia	Orthodontia	\$1,975-2,175	50%	50%
	Limits:	Adults & Child(ren)	Adults & Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology 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 limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then 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. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00441291

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network 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 (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-I-DG2000 et al.
- This policy provides dental coverage only. This policy provides managed care dental benefits through a network of participating general dentists and specialty care dentists. Except for limited emergency services, benefits will be provided for services provided by the primary care dentist selected by the member. The member must pay the primary care dentist a patient charge/copayment for most covered services. No benefits will be paid for treatment by a specialist unless the patient is referred by his or her primary care dentist and the referral is approved under the policy. Only those services listed in the policy's schedule of benefits are covered. Certain services are subject to frequency or other periodic limitations. Where orthodontic benefits are specifically included, the policy provides for one course of comprehensive treatment per member. Unless specifically included, the Managed Dental Care policy does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed Dental Care policy. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The applicable Managed Dental Care documents are the final arbiter of coverage. See your Certificate for complete specifics of all Exclusions and Limitations. All products, unless otherwise noted, are underwritten by The Guardian Life Insurance Company of America ("Guardian") or one of the following wholly-owned Guardian subsidiaries: Managed Dental Care (CA); First Commonwealth Insurance Company (IL); First Commonwealth Limited Health Services Corporation (IN); First Commonwealth of Missouri, Inc. (MO) and Managed DentalGuard, Inc. (NJ, OH and TX). Any reference to a specific product type, including but not limited to "DHMO" or "Prepaid" is not intended to refer to a specific state license designation, but rather is merely intended to refer to a general product design. Such DHMO, or prepaid products, are licensed in the applicable jurisdiction. In addition, certain products are underwritten by Dominion Dental Services, Inc. (DC, DE, MD, PA and VA) and LIBERTY Dental Plan of Nevada, Inc. (NV). Please see the applicable policy forms for details. In the event of conflict between this brochure and the policy forms, the policy forms shall control.
- **PPO and or Indemnity 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

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Managed Dental Care's Managed DentalGuard DHMO Plan The Fine Print

Managed DentalGuard — a DHMO plan from Managed Dental Care (MDC), a wholly owned subsidiary of Guardian — combines broad dental coverage with a number of cost-saving features for you and your family. Many procedures are covered at no cost to you. There are no claim forms to complete, no yearly deductibles and no yearly maximums.

Emergency Dental Services

The MDG plan covers emergency dental services at home and away. Emergency dental services are defined as dental services limited to procedures administered in a dentist's office, dental clinic or other comparable facility, to evaluate and stabilize dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the plan. Services related to the initial emergency condition but not required specifically to relieve pain, discomfort, bleeding or swelling, or to prevent imminent tooth loss, including services performed at the emergency visit and services performed at subsequent visits, are not considered emergency dental services.

Emergency Care at Home

Managed Dental Care provides emergency dental services 24 hours a day, seven days a week. You need only contact your primary care dentist, who will make arrangements for necessary care. If you are unable to reach your primary care dentist during business hours, you should call the MDC Member Services Department for instructions. If you can't reach your primary care dentist and the emergency occurs after normal business hours, you should seek emergency dental services from any licensed dentist. Then submit the bill to MDC with evidence of payment and an explanation of your primary care dentist's unavailability. MDC will reimburse the cost of emergency dental services, less any applicable patient charge.

Emergency Care Outside the Area

MDC provides coverage for emergency dental services required while you are temporarily more than 50 miles away from your primary care dentist's office. You should seek care from a licensed dentist, and then, within 60 days, file your claim including a complete statement of services provided. MDC will reimburse covered services up to \$50 per incident.

Alternative Treatment

If you select a more expensive alternative procedure over the procedure recommended by your primary care dentist, you will be responsible for the difference between your primary care dentist's usual and customary charges for the recommended procedure and the alternative procedure, plus any applicable patient charge for the recommended procedure.

Crowns, Bridges and Dentures

The replacement of a crown, bridge or denture is not covered within five (5) years of the original placement under the plan, except when clinically necessary as determined by your primary care dentist.

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures includes limited follow-up care only for six months, and does not include required future rebasing or relining procedures or a complete new denture.

Multiple Crown/Bridge Unit Treatment Fee

If your primary care dentist recommends a treatment plan including six or more units of crown and/or bridge, you will be responsible for both the usual crown or bridge patient charge for each unit, plus an additional charge per unit.

Crown Supporting Existing Partial Denture

An additional patient charge applies to a crown placed under an existing partial denture when the crown must be customized to physically support the metal framework of the partial denture. You will be responsible for both the patient charge for a crown supporting an existing partial denture and the patient charge for the crown itself. The additional patient charge for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the member is responsible for the additional charge for a multiple crown/bridge unit treatment plan.

Pediatric Specialty Service

A referral to a pediatric specialty care dentist is available for members under the age of six, if they are unmanageable at a visit to their primary care dentist. Referrals are for the current treatment plan only, and members must return to the primary care dentist for further services and referral, if necessary.

After the member's sixth birthday, pediatric specialist services are not covered and the member is responsible for the specialist's usual and customary charges.

Second Opinion Consultation

The MDG plan provides a benefit for a second opinion consultation regarding services recommended by your primary care dentist or by a participating specialist dentist. You must call or write Member Services for authorization before arranging for the second opinion.

We only cover a second opinion consultation when the recommended services are otherwise covered under the plan.

Member Services will help you identify a participating dentist to perform the second opinion consultation, or you may request a second opinion with a non-participating dentist. The plan's benefit for a second opinion consultation is limited to fifty dollars (\$50). If a participating dentist provides your consultation, there is no cost to you. If you choose a non-participating dentist to provide the consultation you will be responsible for the portion of the fee in excess of fifty dollars (\$50).

Noble and High Noble Metals

The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. If you choose high noble metal, you will be responsible for the usual patient charge for the inlay, onlay, crown or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

Orthodontic Treatment

The plan covers orthodontic services as shown in the *List of Covered Services and Patient Charges* for services that are started and completed under this plan, limited to one course of treatment per member per lifetime. Treatment must be pre-authorized by MDC and must be performed by a participating orthodontic specialty care dentist.

The plan covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, you must pay an additional charge for each additional month of treatment, based on the participating orthodontist's contracted fee.

Retention services are covered at the patient charge shown in the *List of Covered Services and Patient Charges* only following a course of comprehensive orthodontic treatment started and completed under this plan.

The plan does not cover any incremental charges for orthodontic appliances made with clear, ceramic, white or other optional material, or lingual brackets. Any additional costs for these materials will be your responsibility.

Only One of the Following Two Paragraphs Applies to Your Plan

If in your plan's *List of Covered Services and Patient Charges*, the patient charge for "comprehensive orthodontic treatment for a dependent child to age 18" (as determined by the member's age on the date of banding) is \$1,975 or greater, then your plan does not have an optional orthodontics-in-progress benefit and the following sentence applies to your plan. **For orthodontic treatment procedures which were started but not completed prior to the member's eligibility to receive benefits under this plan, refer to the "Treatment Started but Not Completed Prior to Eligibility Under this Plan" section.**

If in your plan's *List of Covered Services and Patient Charges*, the patient charge for "comprehensive orthodontic treatment for a dependent child to age 18" (as determined by the member's age on the date of banding) is either \$1,000 or \$1,500, then your plan has an optional orthodontics-in-progress benefit and the following sentences apply to your plan. **For orthodontic treatment procedures for an employee or spouse which were started but not completed prior to the member's eligibility to receive benefits under this plan, refer to the "Treatment Started but Not Completed Prior to Eligibility Under this Plan" section. However, for dependent children, prorated orthodontic benefits may be provided if comprehensive orthodontic treatment was started prior to the member's 19th birthday, has not exceeded 24 months, and is in progress as of the member's effective date under the MDG plan.**

Limitations

The plan does not cover services in excess of any of the following limitations:

- ☐ Routine cleaning or periodontal maintenance procedure — two (2) in any twelve (12) month period.
- ☐ Fluoride treatment — to the 18th birthday, two (2) in any twelve (12) month period.
- ☐ Full mouth x-rays — one (1) set in any three (3) year period unless diagnostically necessary.
- ☐ Bitewing x-rays — two (2) sets in any twelve (12) month period unless diagnostically necessary.
- ☐ Panoramic x-rays — one (1) in any three (3) year period unless diagnostically necessary.
- ☐ Sealants — molars only, to the 16th birthday — one (1) per tooth in any three (3) year period.
- ☐ Periodontal scaling and root planing one (1) service per quadrant in any twelve (12) month period.
- ☐ Gingival flap or osseous surgery — a total of one (1) procedure per quadrant or area in any three (3) year period.
- ☐ Periodontal soft tissue graft — a total of one (1) procedure per area in any three (3) year period.
- ☐ Emergency dental services when more than 50 miles from the primary care dentist's office — limited to a fifty dollar (\$50) reimbursement per incident.
- ☐ Reline of a complete or partial denture — one (1) per denture in any twelve (12) month period.
- ☐ Rebase of a complete or partial denture — one (1) per denture in any twelve (12) month period.
- ☐ Second opinion consultation — when approved by MDC, a second opinion consultation will be reimbursed up to fifty dollars (\$50).

Exclusions

The plan does not cover:

- ☐ Any condition for which benefits are recoverable under any Workers' Compensation or Occupational Disease Law.
- ☐ Dental services performed in a hospital or related hospital fees.
- ☐ Treatment of congenital and/or developmental malformations.
- ☐ Histopathological exams, removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.

- ☐ Oral surgery requiring the setting of a fracture or dislocation.
- ☐ Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- ☐ Any treatment or appliance requested, recommended or performed, which in the opinion of the participating dentist is not necessary for maintaining or improving the Member's dental health, or which is solely for cosmetic purposes.
- ☐ Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- ☐ The use of general anesthesia, intramuscular sedation, intravenous sedation, or inhalation sedation, including but not limited to nitrous oxide.
- ☐ Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- ☐ Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- ☐ Any member request for specialist services or treatment which can be routinely provided by the primary care dentist, or treatment by a specialist without referral from the primary care dentist and Managed Dental Care's approval.
- ☐ Treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- ☐ Any restoration, service, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) replace tooth structure lost due to attrition or abrasion; or (3) splint or stabilize teeth for periodontal reasons.
- ☐ Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- ☐ Dental services, other than covered emergency dental services, received from any dentist other than the member's primary care dentist, unless expressly authorized in writing by the plan.
- ☐ Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- ☐ Consultations for non-covered services.
- ☐ Treatment which requires the services of a prosthodontist.

- ☐ Treatment which requires the services of a pediatric specialist dentist, after the member's sixth birthday.
- ☐ Any procedure not specifically listed as a benefit.
- ☐ Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- ☐ Any service or procedure started but not completed prior to the member's eligibility to receive benefits under this plan.
- ☐ Any service or procedure started by a non-participating dentist. This exclusion will not apply to services that were covered under the plan as emergency dental services.
- ☐ Extractions performed solely to facilitate orthodontic treatment.
- ☐ Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- ☐ Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- ☐ Procedures performed to facilitate non-covered services, including but not limited to root canal therapy to facilitate either hemisection or root amputation and osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- ☐ Procedures, appliances or devices to guide minor tooth movement or to correct or control harmful habits.
- ☐ Any endodontic, periodontal, crown or bridge abutment procedure performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- ☐ Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- ☐ Replacement or repair of orthodontic appliances damaged due to the neglect of the member.

Contract #GP-I-MDCI et al.

Managed Dental Care,
6200 Canoga Avenue, Woodland Hills, CA 91367

A wholly owned subsidiary of
The Guardian Life Insurance Company of America,
New York, NY 10004

Managed DentalGuard

Plan Schedule – 45G

MDG Codes ++	Covered Services	Patient Charges	MDG Codes ++	Covered Services	Patient Charges
Appointments & Diagnostic Services			Crown, Bridge & Other Cast Restorations		
0101*	Office visit - during regular hours - participating general dentist only	NO CHARGE	2510	Inlay - metallic - one surface**	\$120.00
0102	Broken appointment (without 24 hours notice)	\$25.00	2520/6520	Inlay - metallic - two surfaces**	\$145.00
0120/0140/0150	Oral evaluation	NO CHARGE	2530/6530	Inlay - metallic - three or more surfaces**	\$150.00
0460	Pulp vitality tests	NO CHARGE	2543/6543	Onlay - metallic - three surfaces**	\$155.00
0470	Diagnostic casts	NO CHARGE	2544/6544	Onlay - metallic - four or more surfaces**	\$165.00
9310	Consultation (by dentist other than practitioner providing treatment)	NO CHARGE	2702	Crown supporting existing partial denture, in addition to crown	\$125.00
9430	Office visit for observation - regular hours - no other service performed	NO CHARGE	2703	Multiple crown and bridge unit treatment plan - per unit	\$125.00
9440	Emergency office visit - after regularly scheduled office hours	\$50.00	2740	Crown - porcelain/ceramic substrate	\$200.00
Radiographs			2750 - 2752	Crown - porcelain fused to metal**	\$195.00
0210	Intraoral - complete series (including bitewings)	NO CHARGE	2790 - 2792	Crown - full cast metal**	\$180.00
0220/0230/0240	Intraoral - periapical or occlusal - single film	NO CHARGE	2810/6780	Crown - 3/4 cast metallic**	\$190.00
0270/0272/0274	Bitewings	NO CHARGE	6210 - 6212	Pontic - cast metal**	\$180.00
0330	Panoramic film	NO CHARGE	6240 - 6242	Pontic - porcelain fused to metal**	\$195.00
Preventive & Space Maintenance			6750 - 6752	Crown - abutment - porcelain fused to metal**	\$195.00
1110/1120	Prophylaxis	NO CHARGE	6790 - 6792	Crown - abutment - full cast metal**	\$180.00
1201/1203	Topical application of fluoride (may include prophylaxis) - child	NO CHARGE	Other Restorative Services		
1310	Nutritional counseling for control of dental disease	NO CHARGE	2910/2920/6930	Recement inlay, crown, bridge	\$5.00
1330	Oral hygiene instruction	NO CHARGE	2930/2931	Prefabricated stainless steel crown	\$15.00
1351	Sealant - per tooth	\$5.00	2932	Prefabricated resin crown	\$45.00
1510	Space maintainer - fixed - unilateral	\$35.00	2940	Sedative filling	\$5.00
1515	Space maintainer - fixed - bilateral	\$65.00	2950/6973	Core buildup, including any pins	\$40.00
1550	Recementation of space maintainer	\$10.00	2951	Pin retention - per tooth, in addition to restoration	NO CHARGE
Restorative			2952/6970	Cast post & core	\$60.00
2110	Amalgam - one surface - primary	\$5.00	2954/6972	Prefabricated post & core	\$45.00
2120	Amalgam - two surfaces - primary	\$5.00	2960	Labial veneer (laminare) – chairside	\$80.00
2130	Amalgam - three surfaces - primary	\$10.00	Endodontics		
2131	Amalgam - four or more surfaces - primary	\$10.00	3110/3120	Pulp cap	\$5.00
2140	Amalgam - one surface - permanent	\$5.00	3220	Therapeutic pulpotomy	\$15.00
2150	Amalgam - two surfaces - permanent	\$10.00	3310	Root canal – anterior	\$80.00
2160	Amalgam - three surfaces - permanent	\$10.00	3320	Root canal – bicuspid	\$95.00
2161	Amalgam - four or more surfaces - permanent	\$10.00	3330	Root canal – molar	\$175.00
2210	Silicate cement - per restoration	\$10.00	3346	Root canal - retreatment – anterior	\$100.00
2330	Resin/composite - one surface, anterior	\$15.00	3347	Root canal - retreatment – bicuspid	\$115.00
2331	Resin/composite - two surfaces, anterior	\$20.00	3348	Root canal - retreatment - molar	\$190.00
2332	Resin/composite - three surfaces, anterior	\$25.00	3410	Apicoectomy/periradicular surgery - anterior	\$115.00
2335	Resin/composite - four or more surfaces or incisal angle, anterior	\$25.00	3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$115.00
2336	Composite resin crown, anterior - primary	\$25.00	3425	Apicoectomy/periradicular surgery – molar - first root	\$125.00
2380	Resin/composite - one surface, posterior - primary	\$20.00	3426	Apicoectomy/periradicular surgery – each additional root	\$50.00
2381	Resin/composite - two surfaces, posterior - primary	\$25.00	3430	Retrograde filling - per root	\$20.00
2382	Resin/composite - three or more surfaces, posterior - primary	\$30.00	Periodontics		
2385	Resin/composite - one surface, posterior - permanent	\$20.00	4210	Gingivectomy or gingivoplasty - per quadrant	\$90.00
2386	Resin/composite - two surfaces, posterior - permanent	\$25.00	4211	Gingivectomy or gingivoplasty - per tooth	\$30.00
2387	Resin/composite - three or more surfaces, posterior – permanent	\$35.00	4240	Gingival flap procedure - including root planing - per quadrant	\$155.00
			4249	Clinical crown lengthening - hard tissue	\$125.00
			4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$235.00
			4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$140.00

Managed DentalGuard

Plan Schedule – 45G

MDG Codes ++	Covered Services	Patient Charges	MDG Codes ++	Covered Services	Patient Charges
	Periodontics (cont.)			Oral Surgery (cont.)	
4270	Pedicle soft tissue graft procedure	\$150.00	7320	Alveoplasty not in conjunction with extractions - per quadrant	\$45.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$165.00	7450	Removal of odontogenic cyst/tumor – up to 1.25cm	\$60.00
4341	Periodontal scaling & root planing – per quadrant	\$40.00	7451	Removal of odontogenic cyst/tumor – over 1.25cm	\$110.00
4355	Full mouth debridement to enable evaluation & diagnosis	\$20.00	7470	Removal of exostosis - maxilla or mandible	\$85.00
4910	Periodontal maintenance procedures (following active therapy)	\$20.00	7510	Incision & drainage of intraoral abscess	\$25.00
4920	Unscheduled dressing change (by other than treating dentist)	NO CHARGE	7960	Frenulectomy (separate procedure)	\$60.00
9951	Occlusal adjustment - limited - per visit	\$10.00		Orthodontic Treatment (covers 24 months active treatment)	
	Prosthodontics (Removable)		8601	Orthodontic evaluation and consultation	\$100.00
5110/5120	Complete denture (including routine post delivery care)	\$220.00	8602	Orthodontic treatment plan and records, including x-rays, study models and photos	\$150.00
5130/5140	Immediate denture (including routine post delivery care)	\$220.00	8070/8080/8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months; dependent child to age 18 (as determined by the Member's age on the date of banding)	\$1975.00
	Partial dentures (including routine post delivery care):		8070/8080/8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months; employee, spouse, or dependent child over age 18 (as determined by the Member's age on the date of banding)	\$2175.00
5211/5212	Resin base - including clasps, rests, teeth	\$175.00	8670	Periodic comprehensive orthodontic treatment visit	NO CHARGE
5213/5214	Cast metal framework with resin base - including clasps, rests, teeth	\$255.00	8680	Orthodontic retention	\$300.00
	Repairs & adjustments:			Miscellaneous Services	
5410/11/21/22	Denture adjustments	\$10.00	9110	Palliative (emergency) treatment - per visit	NO CHARGE
5510/5610	Repair denture base	\$15.00	9215	Local anesthesia	NO CHARGE
5520/5640	Replace missing or broken teeth – per tooth	\$15.00			
5630	Repair or replace clasp	\$15.00			
5650	Add tooth to existing partial	\$15.00			
5660	Add clasp to existing partial	\$20.00			
5710/11/20/21	Rebase denture	\$50.00			
5730/31/40/41	Reline denture (chairside)	\$25.00			
5750/51/60/61	Reline denture (laboratory)	\$40.00			
5820/5821	Interim partial denture (stayplate)	\$90.00			
5850/5851	Tissue conditioning	\$15.00			
	Oral Surgery				
7110/7120	Extraction - single tooth	\$5.00			
7130	Root removal - exposed roots	\$15.00			
7210	Surgical removal of erupted tooth	\$35.00			
7220	Removal of impacted tooth - soft tissue	\$50.00			
7230	Removal of impacted tooth - partially bony	\$70.00			
7240	Removal of impacted tooth - completely bony	\$80.00			
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$85.00			
7250	Surgical removal of residual tooth roots (cutting procedure)	\$40.00			
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$60.00			
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$90.00			
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$60.00			
7285	Biopsy of oral tissue - hard	\$45.00			
7286	Biopsy of oral tissue - soft	\$40.00			
7310	Alveoplasty in conjunction with extractions - per quadrant	\$35.00			

++ Covered Services are subject to exclusions, limitations and Plan provisions. Other codes may be used to describe Covered Services.

** If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

■ Plan Schedules are only Valid for Covered Services rendered by Participating Dentists in the State of California.

Dental Maximum Rollover[®]

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
\$1000	\$500	\$250	\$350	\$1000
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed \$2,000 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

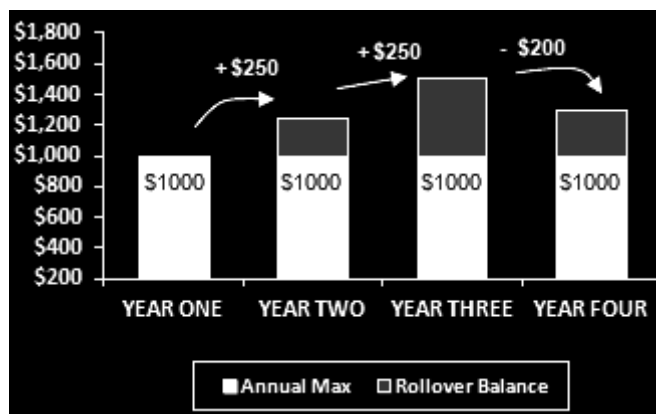
Here's how the benefits work:

YEAR ONE: Jane starts with a \$1,000 Plan Annual Maximum. She submits \$150 in dental claims. Since she did not reach the \$500 Threshold, she receives a \$250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of \$1,250. This year, she submits \$50 in claims and receives an additional \$250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of \$1,500. This year, she submits \$1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is \$1,300 (\$1,000 Plan Annual Maximum + \$300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply.

Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.