EVIDENCE OF COVERAGE

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

GROUP DENTAL COVERAGE

This evidence of coverage verifies that the Employee to whom this booklet is issued is covered by the Plan Sponsor for the benefits described herein, provided the eligibility requirements are met.

The Employee is not covered by any part of the Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Planholder: CITIZENS MEMORIAL HOSPITAL

Group Plan Number: 00543041

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.0015

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IMPORTANT NOTICE

The Dental benefits are directly funded through and provided by your Employer, and are not insured by Guardian. Guardian supplies administrative services, such as: claims services and preparation of Employee benefit booklets.

Your Employer, has the sole responsibility and liability for payment of these benefits.

As used in this booklet, the terms:

- "certificate" refers to this booklet describing the benefits directly funded through and provided by your Employer;
- "insurance" and "insured" refers to the benefits directly funded through and provided by your Employer;
- "plan", "we", "us" and "our" refer to the benefits that are directly funded through and provided by your Employer, and are not insured by Guardian;
- "premium," "premiums," and "premium charge" refer to payments required from you for coverage under this plan; and
- "proof of insurability" refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this booklet will be applicable to these benefits provided by your Employer.

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

Limitation of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to any contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

Incontestability

This Certificate is incontestable after two years from its date of issue, except for non-payment of premiums.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

B400.0016

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL INSURANCE COVERAGE

B400.0018

All Options

Employee Eligibility

You are eligible for Dental coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for Dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Certificate.

B400.0029

All Options

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mental incapacity. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

- The condition started before he or she reached the age limit; and
- The child remained continuously covered until he or she reached the age limit; and
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under this Policy as the Employee.

B400.0036

All Options

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

B400.0087

All Options

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Dental Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Dental Policy as stated in the Conditions Of Eligibility for Group Dental Insurance section; and
- You and Your eligible dependents have enrolled in the Dental Policy; and
- Required premiums have been paid.

You or Your eligible dependents may be considered a Late Entrant if You fail to enroll within 31 days of the Eligibility Date or a Qualifying Event. Late Entrant penalties may be imposed. Please refer to Your Schedule of Benefits.

B400.0091

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.0094

All Options

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for or by You.
- The date You die.

B400.0109

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B400.0115

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with Your Employer or administrator.

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

COBRA Continuation Rights

If dental insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit our website at www.guardianlife.com.

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B400.0120

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B400.0133

DENTAL CLAIM PROVISIONS

After Guardian pays its portion of the Covered Charges, You are responsible for the rest. This includes any Deductible, Copayment, Coinsurance and amounts above any coverage maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B400.0178

All Options

Filing A Claim

Most Dentists file claims electronically or have claim forms on hand. If they don't, You may obtain one by visiting our website at www.guardianlife.com or You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card. We will furnish You a claim form within 15 days of Your request.

You may need to submit Your own claim. Just follow these easy steps to ensure efficient processing:

- Complete Your portion of the claim form and present the form to the Dentist for completion.
- Mail Your completed claim form to the address shown on the Guardian claim form or You can obtain our address on the Guardian website at www.guardianlife.com.

You must submit all claims for dental benefits within 12 months of the date of service.

We may require additional information to pay Your claim. This may consist of radiographic images, periodontal charting, narratives and other diagnostic materials that may support Your claim.

B400.0179

All Options

Coordination Of Benefits (COB)

A Covered Person may have dental insurance through multiple plans. When that occurs one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.

- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to the Employee is primary.
- A plan that provides coverage for an active Employee will be primary over a retiree plan.
- If a child is covered under both parents' plans:
    - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
    - When the parents are separated and not living together:
        - Any applicable court order will apply.
        - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
        - With no court order, benefits will be coordinated in the following order: (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When Guardian is primary, benefits are determined as if no other plan exists.

When Guardian is secondary, benefits are determined so that the total payable by both plans does not exceed the allowable amount, (described below):

- If both plans are subject to a contracted fee schedule, the higher fee schedule is the allowable amount.
- If only one plan is subject to a contracted fee schedule:
    - When the primary plan is not subject to a fee schedule, Guardian's fee schedule is the allowable amount.
    - When the primary plan is subject to a fee schedule, the primary plan's fee schedule is the allowable amount.
- If neither plan is subject to a contracted fee schedule, the maximum allowed amount of either plan is the allowable amount.

In no instance will Guardian pay more as the secondary plan than it would have paid being the primary plan.

B400.0186

Options E , F , G , H

How We Pay Orthodontic Claims

Orthodontic services may or may not be covered under this Policy. Please refer to Your Schedule of Benefits.

Benefits for orthodontic claims are divided into equal payments, which will be paid over the lesser of: (a) the length of the treatment plan; or (b) two years. The first payment is made when the Appliance is placed. Remaining payments are made at the end of each quarter.

If Your orthodontic treatment began prior to Your Eligibility Date, benefits will be prorated by the portion of the treatment incurred while insured with Guardian.

Any orthodontic Lifetime maximum amount paid under a Prior Policy, will be deducted from this Policy's orthodontic Lifetime Maximum.

B400.0188

DENTALGUARD PREFERRED - THIS PLAN'S PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

This Policy's benefits are paid the same for Covered Charges furnished by Contracted Dentists and Non-Contracted Dentists, however, a Covered Person will usually be left with less out-of-pocket expense when a Contracted Dentist is used.

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers as shown below. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.

- DentalGuard Preferred Gold
- DentalGuard Preferred Silver

B400.0280

All Options

Contracted Dentists

Dentists who are contracted with Guardian's DentalGuard Preferred Provider Organization have agreed to accept a discount for the Covered Services they perform. When You visit one of these Dentists, the discount will lower Your out-of-pocket costs.

When receiving services from a Contracted Dentist, You will be responsible for any Deductible, Copayment, Coinsurance amounts above the Benefit Year Maximum and for any non-covered services. In some instances, You may be responsible for the difference between the Dentist's discounted fee and the plan allowance. For Covered Services, You will not be responsible for amounts above the Dentist's discounted fee.

Some states allow Contracted Dentists to accept discounts only on services that are covered by the Policy. Prior to Your anticipated dental services being performed, ask Your Dentist for a treatment plan that includes services to be provided with an estimated cost. (Please see Pre-Treatment Review section). If You would like more information, You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card.

You will need to verify if Your Dentist is contracted within Guardian's Dental Preferred Provider Organization at the time of service.

Please refer to Guardian's on-line provider directory at www.guardianlife.com.

If Your Policy provides orthodontics, the negotiated discounted fee for orthodontics does not include:

- Any incremental charges for optional orthodontic Appliances.

- Replacement or repair due to neglect of the patient.
- Treatment plans that began prior to the Eligibility Date.

B400.0189

All Options

Non-Contracted Dentists

You may visit any Dentist. After Guardian pays its portion of Covered Charges, You are responsible for the rest. This includes Your Deductible, Copayment, Coinsurance and amounts above the Benefit Year Maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B400.0190

COVERED CHARGES

To be a Covered Charge, the service must be:

- Performed by a licensed Dentist; and
- Necessary and appropriate for Your condition; and
- An eligible Covered Service as described in the Schedule of Benefits.

We may use the professional review of a licensed Dentist to determine the appropriate benefit for a dental procedure or course of treatment. We may apply an Alternate Treatment benefit when a less expensive service can be used to treat the dental condition.

Certain comprehensive dental services have multiple procedures. For benefit purposes, these separate procedures will be considered part of the more comprehensive service.

You and Your Dentist have the right and responsibility for choosing the course of treatment and the services to be performed, regardless if those services are covered under this Policy. Once services have been performed and the claim submitted, We will review the claim and determine the benefits payable under this Policy.

All covered charges are considered incurred on the date services are furnished, with the following exceptions:

- Charges for crowns, bridges and other cast restorations are incurred on the date the tooth is initially prepared.
- Charges for root canals are incurred on the date the pulp chamber is opened.
- Charges for dentures are incurred on the date the final impression is made.
- The initial charge for orthodontic treatment is incurred on the date the Appliance is first placed.

Please refer to Your Schedule of Benefits.

B400.0191

All Options

Pre-Treatment Review

To assist You in managing Your total costs, Guardian offers a "Pre-Treatment Review".

A Dentist may submit a treatment plan to Guardian for review before services are performed. Guardian will advise the patient and the Dentist what services are covered and what the estimated payment would be. The actual payment for the predetermined services depends on eligibility, Policy limitations, Coordination of Benefits and the remaining maximum available at the time services are performed. A Pre-Treatment Review is subject to change based on the Dentist's participation status at the time of treatment. A Pre-Treatment Review is optional, however it is strongly recommended for non-routine dental services. Once the services are completed, the claim should be submitted to Guardian for payment.

B400.0192

All Options

Replacing a Prior Policy

If this Policy is replacing a Prior Policy, in the first Policy year; (a) We will reduce the Deductible amount applied under the Prior Policy from this Policy's Deductible; and (b) the maximum amount paid under the Prior Policy will be deducted from this Policy's Benefit Year Maximum. Documentation for Prior Policy benefits must be provided.

B400.0193

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.0292

All Options

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.0335

All Options

Alternate Treatment: This term means if more than one type of service can be used to treat a dental condition, We have the right to base benefits on the least expensive service, which is within the range of professionally accepted standards of dental practice as determined through the professional review of a licensed Dentist.

B400.0294

All Options

Anterior Teeth: This term means the incisor and cuspid teeth. These are the teeth located in front of the bicuspids (pre-molars).

B400.0295

All Options

Appliance: This term means any dental device other than a Dental Prosthesis.

B400.0296

All Options

Benefit Year: This term means a 12 month period which starts on January 1st and ends on December 31st of each year.

B400.0361

All Options

Benefit Year Maximum: This term means the total dollar amount that Guardian will pay for Covered Services by a Covered Person in a Benefit Year.

B400.0298

All Options

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B400.0299

All Options

Coinsurance: This term means the percent of the benefit that Guardian will pay after the required Deductible has been met.

B400.0303

All Options

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Guardian to participate in Guardian's dental network.

B400.0300

All Options

Copayment: This term means a fixed dollar amount that the Covered Person is required to pay at the time services are rendered.

B400.0304

All Options

Covered Person: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B400.0301

All Options

Covered Services: This term means services for which any reimbursement is available under the Employee's Certificate of Coverage, regardless of whether the reimbursement is contractually limited by a Deductible, Copayment, Coinsurance, service waiting period, Benefit Year Maximum or Lifetime Maximum, frequency, alternate benefit payment, or other limitations.

B400.0363

All Options

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B400.0305

All Options

Dental Prosthesis: This term means a restoration or device which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) bridge retainer crowns, inlays, and onlays; (2) bridge pontics; (3) complete and immediate dentures; (4) partial dentures; and (5) (a) crowns; (b) inlays (c) onlays (d) veneers; (e) implants; and (f) posts and cores.

B400.0306

All Options

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Policy.

B400.0307

All Options

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B400.0312

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

B400.0313

All Options

Employee: This term means the member of the group determined to be eligible by the Employer.

B400.0310

All Options

Employer: This term means the entity that purchased this Policy.

B400.0311

All Options

Full-time: This term means:

You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 20 hours per week), at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B400.0318

All Options

Injury: This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Policy; and (2) all complications arising from that damage. But the term does not include damage to teeth, Appliances or Dental Prostheses which results solely from chewing or biting food or other substances.

B400.0316

All Options

Late Entrant: This term means a person who: (1) becomes covered by this Policy more than 31 days after the Covered Person is eligible; or (2) becomes covered again, after the Covered Person's coverage lapsed because he or she did not make required payments.

B400.0319

Options E , F , G , H

Lifetime Maximum: This term means the maximum amount that Guardian will pay for Covered Services during a Covered Person's lifetime.

B400.0320

All Options

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Guardian to provide dental services

B400.0321

All Options

Policy: This term means the group Dental Insurance Coverage described in the Policy and this Certificate.

B400.0324

All Options

Posterior Teeth: This term means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

B400.0326

All Options

Prior Policy: This term means the Employer's plan of group dental coverage which was in force immediately prior to this Policy. For a plan to be considered a Prior Policy, the Guardian Policy must start immediately after the prior coverage ends.

B400.0328

All Options

Qualifying Event: This term means a specific occurrence that changes a Covered Person's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental plan; divorce; death of Your Spouse; termination of another dental policy; or any other event as required by state or federal law or in accordance with Your Employer's rules.

B400.0330

All Options

Spouse: This term means the person to whom You are legally married, as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage was recorded.

B405.0567

All Options

We, Us, Our and Guardian: These terms mean The Guardian Life Insurance Company of America.

You, Your or Yourself: These terms mean the covered Employee.

B400.0334

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Dental benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

If you have questions about this section, see your plan administrator.

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from the plan administrator.

The plan administrator is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. The plan administrator has the authority to determine eligibility for benefits and coverage under those documents. The plan administrator has the right to secure independen professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, the plan administrator will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B434.1723

All Options

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing For Initial Benefit Determination

The Benefit Determination period begins when a claim is received. The plan administrator, or its designee will make a Benefit Determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse Benefit Determination must be provided.

The plan administrator, or its designee will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if the plan administrator, or its designee determines that an extension is necessar due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period the plan administrator, or its designee determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If the plan administrator, or its designee extends the time period for making a Benefit Determination due to a claimant s failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim is denied, the plan administrator, or its designee will provide a notice that will set forth:

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant s right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. The plan administrator, or its designee will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, the plan administrator, or its designee will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a dental or medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination; and

- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

The plan administrator, or its designee will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if The plan administrator, or its designee determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event the plan administrator, or its designee denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant s claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

B434.1724

BASE PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION A

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.comto confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
BENEFIT YEAR DEDUCTIBLE	
Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	$25.00
Deductible Waived for Preventive Services	Yes
Deductible Waived for Basic Services	No
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	No Coverage
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$750.00
Preventive services do not apply to the Benefit Year Maximum	Included

BENEFIT YEAR MAXIMUM (Cont.)	
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	
LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months

BASE PLAN

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

BASE PLAN

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Not Covered	
Inlays, Onlays, Labial veneers	Not Covered	
Post and core, Core buildup	Not Covered	
Crown repair, Bridge repair	Not Covered	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Not Covered	
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		
Fixed partial denture retainer crowns and pontics (Bridge)	Not Covered	
Dentures, complete and partial	Not Covered	
Adding teeth to partial dentures	Not Covered	
Denture repairs	Not Covered	
Denture rebase	Not Covered	
Denture reline	Not Covered	
Denture adjustments	Not Covered	
Tissue conditioning	Not Covered	
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Implant/abutment supported crown or retainer for fixed partial denture	Not Covered	
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Not Covered	
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Not Covered	
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Not Covered	
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

BASE PLAN

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BASE PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION B

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.

Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26

PLAN BENEFITS

Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	$25.00
Deductible Waived for Preventive Services	Yes
Deductible Waived for Basic Services	No

COINSURANCE

Preventive Services	100%
Basic Services	80%
Major Services	No Coverage

BENEFIT YEAR MAXIMUM

Individual Benefit Year Maximum	$750.00
Preventive services do not apply to the Benefit Year Maximum	Included

BENEFIT YEAR MAXIMUM (Cont.)	
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	
LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Not Covered	
Inlays, Onlays, Labial veneers	Not Covered	
Post and core, Core buildup	Not Covered	
Crown repair, Bridge repair	Not Covered	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Not Covered	
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		
Fixed partial denture retainer crowns and pontics (Bridge)	Not Covered	
Dentures, complete and partial	Not Covered	
Adding teeth to partial dentures	Not Covered	
Denture repairs	Not Covered	
Denture rebase	Not Covered	
Denture reline	Not Covered	
Denture adjustments	Not Covered	
Tissue conditioning	Not Covered	
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Implant/abutment supported crown or retainer for fixed partial denture	Not Covered	
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Not Covered	
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Not Covered	
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Not Covered	
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BASE PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION C

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.

Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26

PLAN BENEFITS

Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	$25.00
Deductible Waived for Preventive Services	Yes
Deductible Waived for Basic Services	No

COINSURANCE

Preventive Services	100%
Basic Services	80%
Major Services	No Coverage

BENEFIT YEAR MAXIMUM

Individual Benefit Year Maximum	$750.00
Preventive services do not apply to the Benefit Year Maximum	Included

BENEFIT YEAR MAXIMUM (Cont.)	
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	
LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months

BASE PLAN

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Not Covered	
Inlays, Onlays, Labial veneers	Not Covered	
Post and core, Core buildup	Not Covered	
Crown repair, Bridge repair	Not Covered	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Not Covered	
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		
Fixed partial denture retainer crowns and pontics (Bridge)	Not Covered	
Dentures, complete and partial	Not Covered	
Adding teeth to partial dentures	Not Covered	
Denture repairs	Not Covered	
Denture rebase	Not Covered	
Denture reline	Not Covered	
Denture adjustments	Not Covered	
Tissue conditioning	Not Covered	
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Implant/abutment supported crown or retainer for fixed partial denture	Not Covered	
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Not Covered	
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Not Covered	
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Not Covered	
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BASE PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION D

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
BENEFIT YEAR DEDUCTIBLE	
Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	$25.00
Deductible Waived for Preventive Services	Yes
Deductible Waived for Basic Services	No
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	No Coverage
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$750.00
Preventive services do not apply to the Benefit Year Maximum	Included

BENEFIT YEAR MAXIMUM (Cont.)	
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	
LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Not Covered	
Inlays, Onlays, Labial veneers	Not Covered	
Post and core, Core buildup	Not Covered	
Crown repair, Bridge repair	Not Covered	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Not Covered	
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		
Fixed partial denture retainer crowns and pontics (Bridge)	Not Covered	
Dentures, complete and partial	Not Covered	
Adding teeth to partial dentures	Not Covered	
Denture repairs	Not Covered	
Denture rebase	Not Covered	
Denture reline	Not Covered	
Denture adjustments	Not Covered	
Tissue conditioning	Not Covered	
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Implant/abutment supported crown or retainer for fixed partial denture	Not Covered	
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Not Covered	
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Not Covered	
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Not Covered	
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BUY UP PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION E

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.comto confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
Individual Benefit Year Deductible	Does not apply
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$1,000.00
Preventive services do not apply to the Benefit Year Maximum	Included
LIFETIME MAXIMUM	
Orthodontic Lifetime Maximum	$1,500.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	

LIFETIME MAXIMUM (Cont.) LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months
Major Services	12 months
Orthodontic Services	24 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

BUY UP PLAN

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
		RESTORATIVE
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation below.**
Crown repair, Bridge repair	Major	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Major	If performed more than 12 months after initial insertion.
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		

BUY UP PLAN

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.** Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Adding teeth to partial dentures	Major	To replace extracted natural teeth. **See missing tooth provision below.**
Denture repairs	Major	
Denture rebase	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Major	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture..
Tissue conditioning	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
ORTHODONTICS		
Limited orthodontic treatment, Interceptive orthodontic treatment, Comprehensive orthodontic treatment	Orthodontic	Allowed on dependent children up to age 19. Coverage includes treatment plan and records, including initial, interim and final records. Fabrication and insertion of Appliances and periodic visits. Orthodontic retention, including fixed and removable initial Appliances and related visits. Surgical placement of temporary anchorage device. Transseptal fiberotomy.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BUY UP PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION F

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.comto confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
Individual Benefit Year Deductible	Does not apply
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$1,000.00
Preventive services do not apply to the Benefit Year Maximum	Included
LIFETIME MAXIMUM	
Orthodontic Lifetime Maximum	$1,500.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	

LIFETIME MAXIMUM (Cont.) LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months
Major Services	12 months
Orthodontic Services	24 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation below.**
Crown repair, Bridge repair	Major	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Major	If performed more than 12 months after initial insertion.
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.** Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Adding teeth to partial dentures	Major	To replace extracted natural teeth. **See missing tooth provision below.**
Denture repairs	Major	
Denture rebase	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Major	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.
Tissue conditioning	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
ORTHODONTICS		
Limited orthodontic treatment, Interceptive orthodontic treatment, Comprehensive orthodontic treatment	Orthodontic	Allowed on dependent children up to age 19. Coverage includes treatment plan and records, including initial, interim and final records. Fabrication and insertion of Appliances and periodic visits. Orthodontic retention, including fixed and removable initial Appliances and related visits. Surgical placement of temporary anchorage device. Transseptal fiberotomy.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BUY UP PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION G

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.comto confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
Individual Benefit Year Deductible	Does not apply
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$1,000.00
Preventive services do not apply to the Benefit Year Maximum	Included
LIFETIME MAXIMUM	
Orthodontic Lifetime Maximum	$1,500.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	

LIFETIME MAXIMUM (Cont.) LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months
Major Services	12 months
Orthodontic Services	24 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
		RESTORATIVE
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation below.**
Crown repair, Bridge repair	Major	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Major	If performed more than 12 months after initial insertion.
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.** Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Adding teeth to partial dentures	Major	To replace extracted natural teeth. **See missing tooth provision below.**
Denture repairs	Major	
Denture rebase	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Major	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.
Tissue conditioning	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.

BUY UP PLAN

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
ORTHODONTICS		
Limited orthodontic treatment, Interceptive orthodontic treatment, Comprehensive orthodontic treatment	Orthodontic	Allowed on dependent children up to age 19. Coverage includes treatment plan and records, including initial, interim and final records. Fabrication and insertion of Appliances and periodic visits. Orthodontic retention, including fixed and removable initial Appliances and related visits. Surgical placement of temporary anchorage device. Transseptal fiberotomy.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

BUY UP PLAN

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BUY UP PLAN

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

OPTION H

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.	
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26
PLAN BENEFITS	
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.	
Individual Benefit Year Deductible	Does not apply
COINSURANCE	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$1,000.00
Preventive services do not apply to the Benefit Year Maximum	Included
LIFETIME MAXIMUM	
Orthodontic Lifetime Maximum	$1,500.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	

LIFETIME MAXIMUM (Cont.) LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	6 months
Major Services	12 months
Orthodontic Services	24 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	**CATEGORY OF SERVICE**	**LIMITATIONS**
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in 12 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Limited to once in 24 months for Covered Persons age 40 and older.
Diagnostic casts	Basic	Covered when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in 12 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Preventive	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Preventive	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will be considered for payment if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months if the Covered Person is age 19 and older.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation below.**
Crown repair, Bridge repair	Major	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Major	If performed more than 12 months after initial insertion.
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 2 prophylaxes or periodontal maintenance in 12 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		

BUY UP PLAN

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.** Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Adding teeth to partial dentures	Major	To replace extracted natural teeth. **See missing tooth provision below.**
Denture repairs	Major	
Denture rebase	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Major	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.
Tissue conditioning	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
ORTHODONTICS		
Limited orthodontic treatment, Interceptive orthodontic treatment, Comprehensive orthodontic treatment	Orthodontic	Allowed on dependent children up to age 19. Coverage includes treatment plan and records, including initial, interim and final records. Fabrication and insertion of Appliances and periodic visits. Orthodontic retention, including fixed and removable initial Appliances and related visits. Surgical placement of temporary anchorage device. Transseptal fiberotomy.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

BUY UP PLAN

All Options

CERTIFICATE AND SCHEDULE OF BENEFITS AMENDATORY RIDER

This Rider amends the Certificate and Schedule of Benefits as follows and is effective on the issue date.

This Rider amends the Certificate by replacing the Non-Contracted Dentists provision with the new provision as shown below.

Non-Contracted Dentists

You may visit any Dentist. After Guardian pays its portion of Covered Charges, You are responsible for the rest. This includes Your Deductible, Copayment, Coinsurance and amounts above the Benefit Year Maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on the 90th percentile of Guardian's Reimbursement Schedule in the Dentist's zip code. Guardian's Reimbursement Schedule is calculated utilizing a combination of industry, third party and internal data. Please refer to Your Schedule of Benefits.

This Rider amends the Schedule of Benefits by replacing the Covered Charges Reimbursement section with the new section as shown below.

Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of Guardian's Reimbursement Schedule for the Dentist's zip code.

This Rider is part of the Certificate. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B434.1408

GC-A-DEN-DG6-20