The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

NON-PEDIATRIC SCHEDULE OF BENEFITS

This Policy includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

The Policy refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. As Your needs change over the time You own this Policy, You may change some of these benefits without replacing or purchasing a new Policy. Some of the provisions of this Policy require automatic changes. For example, when a Dependent no longer qualifies for coverage under this Policy due to their age, that Dependent's coverage will terminate.

Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	The Effective Date Approved by Us
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

Non-Pediatric (Adult) Schedule for Covered Persons Age 19 and Over

Cash Deductible Information

Deductible per Insured per Benefit Year
(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services $50.00

Non-Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services $100.00

Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

Preferred Provider Payment Rate for:
Group I Services 100%
Group II Services 60%
Group III Services 50%
Group IV (Orthodontic) Services 0%

Non-Preferred Provider Payment Rate for:
Group I Services 70%
Group II Services 40%
Group III Services 30%
Group IV (Orthodontic) Services 0%

Maximums and Waiting Periods

Preferred Provider & Non-Preferred Provider Annual Maximum
Annual Maximum per Covered Person $800.00

Preferred Provider & Non-Preferred Provider Waiting Periods
Group I Services..... None
Group II Services.....6 Months
Group III Services.....12 Months

How It Works

This Policy is designed to provide high quality dental care while controlling the cost of such care. To do this, this Policy encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with The Guardian Life Insurance Company of America's dental preferred provider organizations (PPOs), which is called DentalGuard Preferred.

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) information about current Preferred Providers.

This Policy usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Policy. Please read this Policy carefully.
A Covered Person may call The Guardian Life Insurance Company of America at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

Covered charges are the charges listed in the applicable fee schedule the Preferred Provider Dentist has agreed to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

A dental service received through the use of audio-visual communication, sometimes called teledentistry, will be considered for benefits just like an in-person service. Teledentistry is provided to you at a different physical location than the dentist, or health professional acting under the delegation and supervision of a dentist, using telecommunications or information technology.

How to Reach Us

Claim Dept.	Customer Care Team	On the Web
P O Box 981587 El Paso, TX 79998-1587	(844) 561-5600	dentalexchange.guardiandirect.com

NON-PEDIATRIC DENTAL SERVICES

List Of Covered Non-Pediatric Dental Services

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be usual and necessary treatment for a dental condition.

Group I Services – (Diagnostic & Preventive)

Prophylaxis/Cleaning and Fluorides

Prophylaxis/cleaning: Limited to a total of one prophylaxis/cleaning or periodontal maintenance procedure in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services (Basic).

Additional prophylaxis/cleaning when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis/cleaning is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Office Visits, Evaluations and Examination

Comprehensive oral evaluation – limited to once every 36 consecutive months. Office visits, oral evaluations, limited oral evaluations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

After-hours office visit or emergency palliative treatment: Limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

Group II Services (Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 36 months have passed since the previous restoration was placed if the Covered Person is age 19 or older.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure

when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Periodontal Services

Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis/cleaning in any six month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis/cleaning under Prophylaxis/Cleaning And Fluorides in Group I Services.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 36 consecutive month period. Considered only when no diagnostic preventive , periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

Periodontal Surgery Related

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

Group III Services (Major)

Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are 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. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.

- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.

- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment.

Root canal retreatment: Limited to once per tooth, per lifetime.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, per lifetime.

Root amputation: Limited to once per root, per lifetime.

Retrograde filling: Limited to once per root, per lifetime.

Hemisection, including any root removal: Once per tooth.

Surgical Extractions

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**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Sialolithotomy.

Sialodochoplasty.

Closure of salivary fistula. Excision of salivary gland.

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under Other Surgical Procedures.

Waiting Periods For Certain Services
The following services when furnished by a Preferred Provider or Non-Preferred Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services

Group III Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

Limitations
Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Policy: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Policy. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Policy.

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 for which benefits are paid by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- 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.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten 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.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device 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.

- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- 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.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- 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.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment, unless the benefit provision provides specific benefits for Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplants.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations**.**
- Dental implants, dental implant abutments.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001
(844) 561-5600

Individual Dental Family Insurance Policy

Pediatric Dental Policy

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	The Effective Date Approved by Us
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

The Guardian Life Insurance Company of America certifies that You are being issued this Policy as the Policyholder for the Dental Insurance described in this Policy. This Policy includes the Schedule of Benefits for the plan. **PLEASE READ THIS POLICY CAREFULLY.**

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT DENTAL INSURANCE POLICY. THIS POLICY PROVIDES DENTAL BENEFITS ONLY. PLEASE READ THIS POLICY CAREFULLY.

RENEWAL AT THE OPTION OF THE COMPANY
This Policy is conditionally renewable and will continue in effect as long as the Policyowner pays the premiums when they are due or within the grace period in accordance with the terms and conditions of this Policy.

You may renew this Policy for a further term by timely payment of renewal, unless We send You prior notice of Our intention not to renew. If We do refuse to renew We must do so on all Policies of this form issued under the same class in Your state. At least 60 days prior to the premium due date, We will send written notice of non-renewal to Your last known address shown on record. Non-renewal will not affect any otherwise valid claim that starts while this Policy is in force.

We reserve the right to change rates on this Policy issued to persons of the same class in Your state. If We do raise Your premium due to a change in rates, then at least 60 days prior to Your renewal date, We will send written notice to You at Your last known address shown on record.

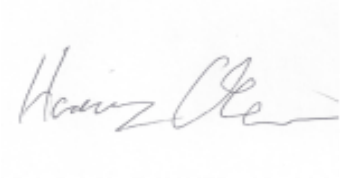
TEN-DAY RIGHT TO EXAMINE POLICY
You have the right to return this Policy to The Guardian Life Insurance Company of America within 10 days of receipt, and to have the premium refunded if, after examination, You are not satisfied with this Policy for any reason.

This Policy is governed by the laws of the State of Illinois.

IN WITNESS OF WHICH, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of the effective date approved by Us, which is its date of issue.



Michael Prestileo, Senior Vice President



Harris Oliner, Senior Vice President and Corporate Secretary

PLEASE NOTE: A larger out-of-pocket expense may occur if Non-Preferred Providers are used

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PEDIATRIC DENTAL SCHEDULE OF BENEFITS FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained below.

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PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services $50.00
Group IV (Orthodontic) Services ..... None

Non-Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services $100.00
Group IV (Orthodontic) Services ..... None

Pediatric Dental Services Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

Preferred Provider Payment Rates:

Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 50%

Non-Preferred Provider Payment Rates:

Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Service 50%

ANNUAL LIMITATION ON COST SHARING
Pediatric Dental Services Maximums and Waiting Periods
Preferred Provider and Non-Preferred Provider Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) .....None

Preferred Provider and Non-Preferred Provider Orthodontics Lifetime Maximum .....None

Preferred Provider Out of Pocket Annual Maximum Per Insured Child $450.00
Preferred Provider Out of Pocket Annual Maximum For Two or More Insured Children $900.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

Non-Preferred Provider Out of Pocket Annual Maximum.....None

Preferred Provider and Non-Preferred Provider Waiting Periods:
Group I, Group II, Group III, and Group IV (Orthodontic) Services ..... None

How It Works

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A Covered Person may call The Guardian Life Insurance Company of America at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

Covered charges are the charges listed in the applicable fee schedule the Preferred Provider Dentist has agreed to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

A dental service received through the use of audio-visual communication, sometimes called teledentistry, will be considered for benefits just like an in-person service. Teledentistry is provided to you at a different physical location than the dentist, or health professional acting under the delegation and supervision of a dentist, using telecommunications or information technology.

How to Reach Us

Claim Dept. P O Box 981587 El Paso TX 79998-1587	Customer Care Team (844) 561-5600	On the Web dentalexchange.guardiandirect.com

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

List of Covered Pediatric Dental Services
The list below provides the Pediatric Dental Services required by your State.

Group I Services (Diagnostic & Preventive)

Prophylaxis/Cleaning And Fluorides

Prophylaxis/cleaning: Limited to a total of one prophylaxis/cleaning in any six consecutive month period. Allowance includes cleaning, scaling and polishing procedures to remove coronal plaque, calculus and stains.

Additional prophylaxis/cleaning when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis/cleaning is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to one treatment in any 12 consecutive month period.

Office Visits, Evaluations And Examination

Comprehensive oral evaluation – limited to once every36 consecutive months per Dentist.

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month periodin an office setting. One every 12 consecutive months in a school setting

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to one evaluation per day per provider or location.

After-hours office visit and Limited emergency exam: Limited to One visit or exam per day per provider or location. Covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Space Maintainers

Space Maintainers: Limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, while covered under this plan.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.
- Removable - bilateral.

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Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph; limited to one in any 36 consecutive month period.

- Full mouth complete series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

Dental Sealants

Dental Sealants or Preventive Resin Restoration: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth. Limited to one treatment, per tooth while covered under this plan.

Group II Services (Basic)
Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 60 consecutive month period.

Protective restoration (sedative filling).

Pin retention per tooth in addition to restoration.

Other Services

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment.

Therapeutic drug injections, injectable antibiotics needed solely for treatment of a dental condition.

Other drugs and/or medicaments, by report

Group III Services (Major)
Restorative Services

Crowns are 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. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement, any restoration, procedure, Appliance or prosthetic device 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; and any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions section for replacement information and limitations.

Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Fixed Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement, replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis; 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; Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis. Also see Exclusions section for replacement information and limitations.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Removable Prosthodontic Services

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation, replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures (upper and lower): Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.

- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Crown and Prosthodontic Restorative Services

Recementation.

- Inlay or onlay.
- Crown.
- Bridge.
- Post and core.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment.

Root canal retreatment: Limited to once per tooth, while covered under this plan.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, while covered under this plan.

Retrograde filling: Limited to once per root, while covered under this plan.

Periodontal Services

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of

each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 6 consecutive month period.

Provisional splinting – intracoronal and extracoronal

Periodontal maintenance: Allowance includes periodontal charting, scaling and polishing.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

Distal or proximal wedge procedure, not in conjunction with osseous surgery.

Pedicle or free soft tissue grafts, including donor site.

Subepithelial connective tissue graft procedure.

Bone replacement grafts.

The treatment listed below is limited to a total of one of following, once per tooth in any 24 consecutive month period.

- Gingivectomy or gingivoplasty.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.

Other Services

General anesthesia, intramuscular sedation, intravenous conscious sedation, non-intravenous conscious sedation or inhalation sedation, and nitrous oxide.

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.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

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**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan.**

Alveoloplasty, per quadrant.

Incision and drainage of abscess.

Excision of tooth related tumors, cysts and lesions.

Treatment of fractures.

Tooth reimplantation.

Surgical access of an unerupted tooth.

Placement of device to facilitate eruption of impacted tooth.

Open reduction of dislocation.

Closed reduction of dislocation.

Frenulectomy, frenuloplasty.

Group IV Services (Orthodontics)

Orthodontic Services

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed to due to severe, dysfunctional, handicapping malocclusion.

- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits. Minor treatment to control harmful habits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

Medically Necessary Orthodontics is defined as a severe, dysfunctional, handicapping malocclusion as determined by a score of 42 points or greater on the modified Salzmann index, or objective documentation that the malocclusion is an impairment of, or a hazard to the ability to eat, chew, speak, or breathe.

Dental beneficiaries are evaluated for orthodontia coverage using medical necessity/handicapping malocclusion criteria as the first level review (Orthodontic Criteria Index Form). If the requested orthodontia treatment meets one of the listed criteria, carriers should approve the request as meeting medically necessary handicapping malocclusion criteria.

If the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form, carriers may proceed with evaluating the request by applying the Salzmann Malocclusion Severity Assessment. A patient must score a 42 or higher to qualify for orthodontia services using the Salzmann Malocclusion Severity Assessment, if the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form. Prior authorization is required to support medical necessity.

Treatment Plan

A treatment plan should always be sent to us before Orthodontic Treatment starts.

How We Pay Benefits for Orthodontic Services

Using the Covered Person’s original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don’t pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original

treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (d) orthodontic treatment started before the member was eligible for orthodontic benefits under this 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 for which benefits are paid by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to characterization and personalization of a Dental Prosthesis.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least $^{6}0$ months 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.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.

- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

DENTAL POLICY OF INSURANCE

This Individual Dental Policy, along with the Schedule of Benefits with exclusions and limitations, and application, provide a complete description of how Your Guardian Life Insurance Company of America dental plan operates, Your benefits and the plan's restrictions and limitations.

ENTIRE CONTRACT; CHANGES

This contract, including the Policy, Schedule of Benefits with exclusions and limitations and Your application form, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this contract or to waive any of its provisions.

If any provision of this Policy is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Policy, but such remaining provisions shall continue in full force and effect unless the illegality and invalidity prevent the accomplishment of the objectives and purposes of this Policy.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy, no misstatements, except fraudulent or intentional misstatements of material fact, made by the applicant in any application shall be used to void the coverage or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

PROHIBITION OF RESCISSION

The Guardian Life Insurance Company of America shall not rescind this Policy once You are covered under the Policy, except if You have performed an act or practice that constitutes fraud or make an intentional misrepresentation of a material fact as prohibited by the terms of this Policy. This Policy shall not be cancelled without prior notice to You.

NOTICE REGARDING YOUR RIGHTS AND RESPONSIBILITIES

Rights:

- The Guardian Life Insurance Company of America will comply with all applicable laws relating to privacy.
- You and Your Dentist are responsible for Your dental treatment. The Guardian Life Insurance Company of America does not require or prohibit any specified treatment. Only certain specified services are covered for benefits.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.

- You may request a written response from The Guardian Life Insurance Company of America to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.
- The Dental Care Patient Protection Act requires Managed Care Dental plans to file a written consumer summary information description. The insurer must also file its grievance procedure and its list of participating provider.
- A stand-alone dental plan covering the pediatric dental EHB must demonstrate that it has a reasonable annual limitation on cost- sharing as determined by the Exchange. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services.

Responsibilities:

- You must pay any charges for services performed by the Dentist. If the Dentist agrees to accept part of the payment directly from The Guardian Life Insurance Company of America, You must pay the remaining part of the Dentist's charge.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Dentist.

ELIGIBILITY AND ENROLLMENT

Who May Enroll

You and any of Your eligible dependents may enroll in this plan. The Guardian Life Insurance Company of America defines eligible dependents as:

- Your spouse, Civil Union Partner or domestic partner.
- Your children or grandchildren, up to age 26, for whom You provide care, including adopted children, step-children, or other children for whom You are required to provide dental care pursuant to a court or administrative order.
- Your children who are incapable of self-sustaining employment and support due to a developmental disability or physical disability.

Unmarried dependent children will be covered until their 30th birthday if they (a) are an Illinois resident, (b) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, (c) has received a release or discharge other than a dishonorable discharge, and (d) the eligible dependent submits to Us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

When Coverage Begins

Coverage will begin on the first day of the month following the date Your premium payment is received by The Guardian Life Insurance Company of America, so long as the premium is received on or before the twentieth (20th) day of the preceding month. Check with The Guardian Life Insurance Company of America if You have any questions about when Your coverage begins.

Minimum Enrollment Period

You must enroll for a minimum of twelve (12) months. Enrollment in this dental coverage beyond Your initial twelve (12) month commitment will be automatically continued until You disenroll. If this dental coverage is purchased through an exchange, then the exchange will determine the enrollment period.

Disenrollment
Enrollment in this dental coverage beyond Your initial twelve (12) month commitment will be automatically continued until You disenroll.

If You disenroll before Your pre-paid rate term expires, You will be charged the monthly rates for any months You were actively enrolled when calculating refund amounts.

Disenrollment may also occur when Your premium payment is not received by the first (1st) of the month following the due date on Your invoice. Please see the "Grace Period" provision below for more information.

Loss of Eligibility
A Covered Person will lose eligibility:

- On the first day of the month for which The Guardian Life Insurance Company of America does not receive the required premium payment, subject to the Grace Period, below;
- On the last day of the month in which a notice of voluntary termination is received;
- On the last day of the month in which he or she no longer meets eligibility requirements.

In the event of contract termination, no further benefits will be provided to You and none of the plan provisions will apply. If You fail to pay the premium through and including the final month of the contract, all coverage may be terminated retroactively to the day prior to when the Grace Period began and no premium is due.

Grace Period
Your payment is due by the first (1st) of the month in which You receive an invoice. If it is not received by the twentieth (20th), it is considered delinquent.

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force (subject to the right of The Guardian Life Insurance Company of America to cancel in accordance with the Termination of Policy provision.) If the account continues to be delinquent for more than thirty-one (31) days, Your enrollment will be terminated retroactively to the day prior to when the Grace Period began.

Termination of Policy
If the required premium is not paid, Your coverage may be canceled not less than thirty-one (31) days after such premium was due.

Reinstatement
If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by The Guardian Life Insurance Company of America or by any agent duly authorized by The Guardian Life Insurance Company of America to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if The Guardian Life Insurance Company of America or such agent requires an application for reinstatement and issues a

conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

OVERVIEW OF DENTAL BENEFITS

The Schedule of Benefits contains the benefits and sets forth the Deductibles, coinsurance amounts, and exclusions and limitations. Please review the Schedule of Benefits carefully to understand what benefits are covered under this plan and Your financial responsibility. The Guardian Life Insurance Company of America dental plan covers "Dentally Necessary" dental care.

This Dental Insurance gives Covered Persons access to Dentists who have contracted with The Guardian Life Insurance Company of America. Contracted Dentists have agreed to limit their charge for a Covered Service to the Maximum Allowed Charge for such service. Under this plan, We pay benefits for Covered Services performed by either Preferred Providers or Non-Preferred Providers. This Guardian Life Insurance Company of America plan usually pays a higher level of benefits for Covered Services furnished by a Preferred Provider. Conversely, it usually pays less for Covered Services furnished by a Non-Preferred Provider. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used.

Deductibles

The Deductible amounts, if any, are shown in the Schedule of Benefits.

Benefit Amounts

We will pay benefits in an amount equal to the Covered Percentage as shown in the Schedule of Benefits for charges incurred for a Covered Service, subject to the conditions set forth in this Policy.

Preferred Provider

If a Covered Service is performed by a Preferred Provider, The Guardian Life Insurance Company of America will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If a Preferred Provider performs a Covered Service, You will be responsible for paying:

- The Deductible, if any; and
- Any other part of the Maximum Allowed Charge for which The Guardian Life Insurance Company of America does not pay benefits.

Non-Preferred Provider

If a Covered Service is performed by a Non-Preferred Provider, The Guardian Life Insurance Company of America will base the benefit on the charge listed in the fee schedule.

Non-Preferred Providers may charge more than the charge listed in the fee schedule. If a Non-

Provider performs a Covered Service, You will be responsible for paying:

- The Deductible; and
- Any other part of the charge for which The Guardian Life Insurance Company of America does not pay benefits.

Pre-Treatment Estimates

Pre-Treatment estimate requests are not required but may be submitted to The Guardian Life Insurance Company of America for more complicated and expensive procedures such as crowns, wisdom teeth extractions, bridges, dentures, or periodontal surgery. When Your Dentist submits a pre-treatment estimate request to The Guardian Life Insurance Company of America, You will receive an estimate of Your share of the cost and how much The Guardian Life Insurance Company of America will pay before treatment begins. A pre-treatment estimate is particularly useful in the following cases:

- If You are having extensive work done and the total charges will exceed $300.00;
- To make sure a particular procedure is covered;
- To see if any maximum benefits will be exceeded; or
- If You need to plan Your payment in advance.

By asking Your Dentist for a Pre-treatment estimate from The Guardian Life Insurance Company of America before You agree to receive any prescribed major treatment, You will have an estimate up front of what the dental plan will pay, and the difference You will need to pay. Your Dentist may also be able to present alternative treatment options that will lower Your share of the bill while still meeting Your dental care needs.

Pre-Authoirzations

You must receive pre-authorization approval for all medically necessary orthodontia that is received under this Policy. No claim for medically necessary orthodontia will be paid unless You or Your Dentist obtains pre-authorization approval, in writing, from The Guardian Life Insurance Company of America prior to receiving any medically necessary orthodontic services.

Customer Care

We provide toll-free access to our Customer Care Team to assist You with benefit coverage questions, resolving problems, or changing or selecting a Dentist. Our Customer Care Team can be reached Monday through Friday at (844) 561-5600 (TTY/TDD 7-1-1) from 9:00 am to 9:00 pm, Eastern Standard Time. Automated service is also provided after hours for eligibility verification.

Selecting Your Dentist

When You enroll in The Guardian Life Insurance Company of America plan, You may receive dental care from:

- A Preferred Provider; or
- A Non-Preferred Provider

Please note that You enjoy the greatest benefits, including out-of-pocket savings, when You choose The Guardian Life Insurance Company of America contracted Dentist. Please refer to the provider directory for a complete listing of The Guardian Life Insurance Company of America's contracted Dentists. Or You may access our website at dentalexchange.guardiandirect.com to view The Guardian

Life Insurance Company of America contracted Dentists. Please check with Your Guardian Life Insurance Company of America Dentist to verify that Your plan is accepted.

Changing Your Dentist

You can choose any Guardian Life Insurance Company of America contracted provider at any time. If You wish to change Dentists, please review The Guardian Life Insurance Company of America's provider directory for Dentists in Your area and call to schedule an appointment. You may also call our Customer Care Team at (844) 561-5600 (TTY/TDD 7-1-1)for assistance in choosing a Dentist.

FILING CLAIMS

Filing a Claim for Dental Insurance Benefits

When You receive services from a Preferred Provider, he or she will file the claim for dental insurance benefits for You. If You need to file a claim Yourself, both the notice of claim and any receipts or other supporting documentation should be sent to The Guardian Life Insurance Company of America as set forth below. You can request a claim form by calling (844) 561-5600 (TTY/TDD 7-1-1) or from our website at https://mydental.guardianlife.com/learn-more/our-plans.

Notice of Claim

Written notice of claim must be given to The Guardian Life Insurance Company of America within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at P O Box 981587 El Paso, TX 79998-1587 or to any authorized agent with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms

Upon a notice of claim, The Guardian Life Insurance Company of America will furnish You with the necessary forms for filing proof of loss. If such forms are not furnished to You within 15 days after receiving such notice, You shall be deemed to have complied with the requirements of this Policy.

Proof of Loss

Written proof of loss must be furnished to The Guardian Life Insurance Company of America within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

If Your claim is a Clean Claim and it is approved by The Guardian Life Insurance Company of America, benefits will be paid within fifteen (15) days after We receive due written proof in electronic form of a covered loss, or within 30 days after receipt of written proof of a covered loss so long as all information, including supporting documentation, is supplied with the claim. If We do not pay all dental benefits within thirty (30) days after We received written proof of loss, We will pay interest at the rate of 9.0% per year from the 30th day after receipt of proof of loss until all dental benefits for the loss have been paid.

Alternative Dental Treatment

If The Guardian Life Insurance Company of America determines that other procedures, services or courses of treatment could be done to correct a dental condition, coverage will be limited to the least costly procedure that We determine will produce a professionally satisfactory result. In order to make a determination, The Guardian Life Insurance Company of America may request x-rays and any other appropriate information from the Dentist.

GENERAL PROVISIONS

Assignment

Your rights and benefits under this Policy are assignable prior to a claim for benefits, as required by law. We are not responsible for the validity of an assignment.

Recovery of Overpayments

The Guardian Life Insurance Company of America has the right to recover any amount it determines to be an overpayment for services received. An overpayment occurs if The Guardian Life Insurance Company of America determines that the total amount paid by The Guardian Life Insurance Company of America on a claim for dental insurance benefits is more than the total of the benefits due under this Policy.

How We Recover Overpayments

We may recover the overpayment from You by:

- Stopping or reducing any future benefits payable for dental insurance under this Policy or any other Policy issued to You by The Guardian Life Insurance Company of America;
- Demanding an immediate refund of the overpayment from You; and
- Taking legal action.

If the overpayment results from our having made a payment to You, We may recover such overpayment.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of two (2) years after the time written proof of loss is required to be furnished.

DEFINITIONS
These definitions apply when the following terms are used, unless otherwise defined where they are used. Not all defined terms are used in their usual meaning and some have meanings that limit their application; therefore, please refer to this Definitions section for a helpful understanding of the defined terms that are capitalized.

Benefit Year: This term means a 12 month period which starts on the Effective Date or the date of your annual renewal, if applicable.

Civil Union Partner: This term means a legal relationship between two persons of the same or opposite sex who form a civil union. Parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. If policies of insurance provide coverage for children, the children of Civil Union Partners must also be provided coverage. Parties to civil unions or same sex civil unions or marriages legally entered into in other jurisdictions are recognized as a Civil Union Partner or Civil Union Partners.

Clean Claim is a claim received by The Guardian Life Insurance Company of America that requires no further information, adjustment, or alteration by the provider of services in order to be processed and paid. A claim is a Clean Claim if it has no defect or impropriety, including a lack of any required substantiating documentation, including x-rays and charts, if required.

Covered Percentage means:

- For a Covered Service performed by a Preferred Provider, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- For a Covered Service performed by a Non-Preferred Provider, the percentage of the charge listed in the fee schedule that The Guardian Life Insurance Company of America will pay for such services after any required Deductible is satisfied.

All Covered Percentages are included in the Schedule of Benefits for each Covered Service.

Covered Person means a person for whom Dental Insurance coverage has been purchased so long as it is in effect under this Policy.

Covered Service means a dental service used to treat a Covered Person's dental condition which is:

- prescribed or performed by a Dentist while the dental insurance provided by this Policy is in effect;
- Dentally Necessary to treat the condition; and
- Described in the Schedule of Benefits as a Covered Service.

Deductible means the amount You must pay before The Guardian Life Insurance Company of America will pay for Covered Services.

Dentally Necessary means the services are required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's dental condition due to dental disease, in order to attain or maintain the individual's achievable dental health, provided that such services are:

- Consistent with generally accepted standards of dental practice that are defined standards and are based on credible scientific evidence published in peer- reviewed

dental literature that is generally recognized by the relevant dental community, recommendations of a dental-specialty academy, the views of Dentists practicing in the relevant clinical areas, and any other relevant factors;

- Clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's dental condition;
- Not primarily for the convenience of the patient or Dentist;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's dental condition; and
- Based on an assessment of the individual and his or her dental condition.

We will not pay dental insurance benefits for charges incurred for:

- Services which are not Dentally Necessary Services, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.
- Services for which You would not be required to pay in the absence of dental insurance.
- Services which are primarily cosmetic (including cosmetic orthodontia.)

Dentist means:

- A person licensed to practice dentistry in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of this Policy. Each such person must be licensed where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required.

Preferred Provider means a Dentist or dental care facility that is under contract with The Guardian Life Insurance Company of America and has a contractual agreement with The Guardian Life Insurance Company of America to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- The amount charged by the Dentist; or
- The charge listed in the fee schedule the Preferred Provider has agreed to accept as payment in full.

Non-Preferred Provider means a Dentist or dental care facility that is not under contract with The Guardian Life Insurance Company of America.

We means The Guardian Life Insurance Company.

You or Your means the Insured.