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

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 and Group II Services.....$100.00

Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider. This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

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

Non-Preferred Provider Payment Rate for:
Group I Services..... 100%

Group II Services 50%
Group III Services 0%
Group IV (Orthodontic) Services 0%

Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximum
Annual Maximum per Covered Person $1,000.00

Preferred Provider and Non-Preferred Provider Waiting Periods
Group I Services ..... None
Group II Services ..... 6 Months

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons who are eligible for the Pediatric Dental Services explained below. Pediatric benefits will be offered through the end of the month during which the insured turns 19 years old.

Pediatric Dental Services Cash Deductible Information

Deductible per Insured Child per Benefit Year

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

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

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 0%

Non-Preferred Provider Payment Rates:
Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 0%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximums:
Group I, Group II, and Group III Services ..... 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 Waiting Periods:
Group I, Group II and Group III Services .....None

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 Guardian'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 Guardian 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 And Fluorides

Prophylaxis: Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) 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 III Services.

Additional prophylaxis 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 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.

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.

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

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

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 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 60 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.
- 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.
- The use of local anesthetic.
- 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.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- With the exception of newborn dependents, treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth. Coverage for newborn dependents consists of coverage of injury or sickness including the necessary care and treatment of dentally diagnosed congenital defects and birth abnormalities.
- Evaluations or treatment for Endodontics, Periodontics or Oral Surgery are not a covered benefit under this Plan.

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

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

List Of Covered Pediatric Dental Services

Group I Services (Diagnostic & Preventive)

Prophylaxis And Fluorides

Prophylaxis: Limited to three prophylaxis in a calendar year.

Additional prophylaxis 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 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.

Office Visits, Evaluations And Examination

Comprehensive oral evaluation

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of two in a calendar year.

Limited oral evaluation – problem focused or emergency oral evaluation.

After-hours office visit or emergency palliative treatment.

Space Maintainers

Space Maintainers. Covered only when necessary to replace prematurely lost or extracted deciduous teeth.

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

Recementation of space maintainer.

Removal of fixed space maintainer.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series; limited to one in any 60 consecutive month period.

- Full mouth complete series, of at least 14 images including bitewings.

Panoramic radiograph; limited to one in any 60 consecutive month period.

- 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 a calendar year.

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.

Group II Services (Basic)

Restorative Services

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.

Pin retention per tooth

Protective restoration

Diagnostic services - Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment.

Pulp vitality tests

Diagnostic casts

Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report

Group III Services (Major)

Group III 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. 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.

Core buildup.

Cast post and core in addition to crown, prefabricated post and core in addition to crown.

Labial veneer.

Prosthodontic Services

Specialized techniques and characterizations 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.

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.

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.

- 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.

Denture reline, full or partial denture.

Denture adjustments.

Tissue conditioning.

Other Services

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

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.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification.

Apicoectomy.

Root amputation.

Retrograde filling.

Hemisection, including any root removal.

Periodontal Services

Periodontal maintenance.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period.

Gingivectomy or gingivoplasty.

Crown lengthening, hard tissue.

Gingival flap procedure, including scaling and root planing.

Apically positioned flap.

Provisional splinting.

Full mouth debridement.

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 Employer's 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 Employer's medical plan.**

Incision and drainage of abscess**.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Frenulectomy, frenectomy, frenotomy.

Surgical access of an erupted tooth.

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Tooth reimplantation.

Biopsy of soft tissue.

Brush biopsy.

Exclusions

The Exclusions listed here apply to Covered Persons under the age of 19.

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 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: (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.
- 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; or (3) treat a condition necessitated by attrition or abrasion.
- 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.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment.
- Prescription medication.

- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.