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

Individual Dental Family Insurance 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 ("Guardian") 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 guaranteed 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.

We reserve the right to change rates on this Policy issued to persons of the same class in Your state, subject to Our filing with and approved by the superintendent of insurance, 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 Guardian 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 Ohio.

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



Harris Oliner
Senior Vice President & Corporate Secretary



Michael Prestileo
Vice President

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

IMPORTANT: IF YOU OPT TO RECEIVE DENTAL CARE SERVICES THAT ARE NOT COVERED BENEFITS UNDER THIS PLAN, A PARTICIPATING DENTAL CARE PROVIDER MAY CHARGE YOU HIS OR HER NORMAL FEE FOR SUCH SERVICES. PRIOR TO PROVIDING YOU WITH DENTAL CARE SERVICES THAT ARE NOT COVERED BENEFITS, THE DENTAL CARE PROVIDER WILL PROVIDE YOU WITH AN ESTIMATED COST FOR EACH SERVICE.

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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.

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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 and Group II 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.

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

Non-Preferred Provider Payment Rate for:
Group I Services 100%
Group II Services 60%
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 $1,500.00

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 under the age of 19 who are eligible for the Pediatric Dental Services explained below.

Pediatric Dental Services Cash Deductible Information

Deductible per Insured Child under the age of 19 per Benefit Year
(Each Insured Child must meet the Deductible shown, if any, each 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) Services 30%

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 Orthodontics Lifetime Maximum ..... None

Preferred Provider Out of Pocket Annual Maximum Per Insured Child under the age of 19...
.....$450.00
Preferred Provider Out of Pocket Annual Maximum For Two or More Insured Children under the age of 19 .....$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 (Orthodontics) 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 II 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 six 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 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.

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.

Periodontal Services

Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis in any six month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis 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.

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.**

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.

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.

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 won't pay 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 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.
- 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.
- 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.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

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 and Fluorides

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

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: Limited to two treatments in any twelve consecutive month period.

Office Visits, Evaluations and Examination

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period.

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.

Radiographs

Allowance includes evaluation and diagnosis.

- Full mouth series, of at least 14 images including bitewings, limited to one in any 60 consecutive month period.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs, limited to one in any 60 consecutive month period.

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 6 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, in any 36 consecutive month period.

Group II Services (Basic)

Restorative Services

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 60 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.

Diagnostic casts.

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, surgical placement of an implant and services listed under Other Surgical Procedures.

Group III Services (Major)

Group III 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.

Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. 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 section for replacement information and other 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, when done in connection with a covered surgical placement of an implant on the same tooth.

- 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.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site.
- Radiographs/surgical implant index: Limited to once per arch in any 60 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Exclusions section for replacement and other 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

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.

- 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 36 consecutive month period. Denture rebases done within 6 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 6 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 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 6 consecutive months after the insertion of the denture.

Denture adjustments.

Tissue conditioning.

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.

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.

- 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.

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: Limited to a total of four periodontal maintenance or prophylaxis in any twelve month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis 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.

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.

Gingivectomy or gingivoplasty, per tooth (less than three teeth) , once in any 36 consecutive month period.

Crown lengthening, hard tissue.

Gingivectomy or gingivoplasty, per quadrant, once in any 36 consecutive month period.

Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant, once in any 36 consecutive month period.

Gingival flap procedure, including scaling and root planing, per quadrant.

Distal or proximal wedge procedure, not in conjunction with osseous surgery, once in any 36 consecutive month period.

Surgical revision procedure, per tooth, once in any 36 consecutive month period.

Pedicle or free soft tissue grafts, including donor site.

Subepithelial connective tissue graft procedure.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier, once in any 36 consecutive month period.

Bone replacement grafts, once in any 36 consecutive month period.

Periodontal Surgery Related

Occlusal guards: Limited to one in any twelve consecutive month period.

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.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Tooth reimplantation.

Other Services

Detailed and extensive oral evaluations – problem focused, by report

Injectable antibiotics needed solely for treatment of a dental condition.

Group IV Services (Orthodontics)

Orthodontic Services

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

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) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect

of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan.

Exclusions

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

We do not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not Dentally Necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations, except Teledentistry, which is under the direct supervision of a dentist;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those services submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those services for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those services which are for specialized procedures and techniques;

- Those services performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 19 and over;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Orthodontic care for a member or spouse
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non benefited service) as determined by Use.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Us.

Discounts on Non-Orthodontic Dental Services Not Covered By This Plan

A Covered Person under this Policy can receive discounts on certain services not covered by this Policy, as described below, if:

(a) he or she receives services or supplies from a Dentist that is under contract with Guardian's dental preferred provider organizations (PPOs) network; and

(b) the service or supply is on the fee schedule the Dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this Policy. The Covered Person must pay the entire discounted fee directly to the Dentist. There is no need to file a claim.

When a person is no longer covered by this Policy, access to the network discount ends.

Discounts on Services Not Covered Due To Contractual Provisions

If a Covered Person receives dental services from a Dentist who is under contract with Guardian's DentalGuard Preferred, such services will be provided at the discounted fee the Dentist agreed to accept as payment in full as a member of our DentalGuard Preferred network, even if such services are not covered by the Policy due to:

(a) meeting the plan's benefit year payment limit provision;

(b) frequency limitations; or

(c) policy exclusions, such as dental implants.

Discounts on Orthodontic Services

If a Covered Person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

(a) pre-orthodontic treatment visit;

(b) limited orthodontic treatment;

(c) interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(d) comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(e) periodic comprehensive orthodontic treatment visit (as part of a contract); or

(f) orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- extractions performed solely to facilitate orthodontic treatment;
- orthognathic surgery and associated incremental charges; and
- replacement of lost or broken retainers.

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 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 misstatements, 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

Guardian 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.

STATEMENTS

No statement will void the insurance under this plan, or be used in defense of a claim hereunder unless it is contained in a written instrument signed by the covered person, a copy of which has been furnished to the covered person or his or her beneficiary.

Absent fraud, all statements made by an applicant or insured are considered to be representations and not warranties.

NOTICE REGARDING YOUR RIGHTS AND RESPONSIBILITIES

Rights:

- Guardian will comply with all applicable laws relating to privacy.
- You and Your Dentist are responsible for Your dental treatment. Guardian 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 Guardian 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.

Responsibilities:

- You must pay any charges for services performed by the Dentist. If the Dentist agrees to accept part of the payment directly from Guardian, 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. Guardian defines eligible dependents as:

- Your spouse 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 or grandchildren will be covered from the moment of birth or date of placement.
- Your children who are incapable of self-sustaining employment and support due to a developmental disability or physical handicap.

If additional monthly premiums will be required to enroll a new spouse or a new dependent child, You must submit an Application/Change Form within thirty-one (31) days of acquiring the new dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. If no additional monthly premium will be required when You add a dependent child to Your plan, You should complete a Status Change Form so that We may send an I.D. card to facilitate the child's access to covered services.

When Coverage Begins

Coverage will begin on the first day of the month following the date Your premium payment is received by Guardian, so long as the premium is received on or before the last day of the preceding month. Check with Guardian 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 or cancel. 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 purchased Your coverage through Your State's Exchange, the Exchange will manage Your ability to disenroll.
If Your coverage was not purchased through Your State's Exchange and 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 (1^{st}) of the month following the due date on Your invoice. Please see the "Grace Period" provision below for more information.

Cancellation by the insured. Non-cancellation by the insurer.

If you purchased Your coverage through Your State's Exchange, the Exchange will manage Your ability to cancel Your policy.

If Your coverage was not purchased through Your State's Exchange, and You wish to cancel this policy, You may do so after the initial twelve (12) month commitment. You must do so cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. The insurer may not cancel this policy. This provision nullifies any other provision, contained in this policy or in any indorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the insured.

Loss of Eligibility

A Covered Person will lose eligibility:

- On the first day of the month for which Guardian 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

For Enrollees receiving an Advanced Premium Tax Credit (APTC):

- If Your premium payment is not received by the first (1st) of the month, a Grace Period of three (3) months will be granted. During the Grace Period, this Policy shall continue in force. We will pay claims for services rendered during the first (1st) month of the Grace Period and will pend claims for services rendered in the second (2nd) and third (3rd) months of the Grace Period. If premiums are received during the Grace Period, You will be reinstated as of the last day of paid coverage. If premiums are not received prior to the end of the Grace Period, Your coverage will be terminated the last day of the first (1st) month of the Grace Period.

For Enrollees not receiving an Advanced Premium Tax Credit (non-APTC):

- A Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. During this time, this Policy shall continue in force. Coverage will terminate at the end of the Grace Period unless We receive Your premium before the end of this thirty-one (31) days.

Termination of Policy

You have the right to terminate coverage under this Policy by sending the Exchange written notice of Your intent to terminate this Policy. The effective date of the termination will be the date reported to the Exchange. If coverage is terminated because You are covered by Medicaid, the last day of coverage with Us is the day before the new coverage is effective.

A full refund of the premium will be issued if a written request is received and a refund is available when the Policy cancellation is received.

You may keep this Policy in force with Your timely payment of the Premiums. However, We may terminate coverage due to:

- You no longer being eligible through the Exchange or under the terms of this Policy;

- Non-payment of premium, subject to the “Grace Period” provision;
- Fraud or material misrepresentation made by You or with Your knowledge, when applying for this coverage or filing a claim for payment. If coverage is terminated, We will provide forty-five (45) days written notice prior to termination. If We fail to provide You with the forty-five (45) day written notice, coverage shall remain in effect at the existing premium until forty-five (45) days after notice is given or until the effective date of replacement coverage is obtained by You. Claims received prior to the effective date of cancellation will be processed in accordance with the standard processing guidelines under this Policy;
- You change to a new policy through the Exchange; or
- We cease to renew all Policies issued on this form to residents of the state/county where You live. We will provide You with a ninety (90) day written advance notice prior to termination.

  If termination is due to loss of eligibility through the Exchange, termination is effective on the last day of the month following the month that the Exchange notifies You of Your lack of eligibility. If You are no longer eligible due to age, termination is effective on the date reported by the Exchange and You should contact the Exchange to see if a special enrollment period applies.

Reinstatement

If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by Guardian or by any agent duly authorized by Guardian to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if Guardian 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 or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application.

If this Policy is terminated, You may re-enroll in the Policy during the next open enrollment period. Any Deductible, maximum, maximum out-of-pocket Maximum, and /or waiting period applicable to Your benefits will start over. However, this Policy may be reinstated, prior to open enrollment, with no break in coverage, provided the full premium due is received by Us. (See “Grace Period”).

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 You and We shall have the same rights thereunder as we both 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 dental plan covers "Dentally Necessary" dental care.

This Dental Insurance gives Covered Persons access to Dentists who have contracted with Guardian. 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 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, Guardian 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 Guardian does not pay benefits.

Non-Preferred Provider

If a Covered Service is performed by a Non-Preferred Provider, Guardian 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-Preferred Provider performs a Covered Service, You will be responsible for paying:

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

Pre-Treatment Estimates

Pre-Treatment estimate requests are not required but may be submitted to Guardian 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 Guardian, You will receive an estimate of Your share of the cost and how much Guardian 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 Guardian 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-Authorizations

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 Guardian prior to receiving any medically necessary orthodontic services.

Customer Service

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. The Customer Care Team can be reached Monday through Friday at (844) 561-5600 (TTY/TDD 7-1-1) from 8:00 am to 8:00 pm, Eastern Standard Time. Automated service is also provided after hours for eligibility verification.

Selecting Your Dentist

When You enroll in the Guardian 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 Guardian contracted Dentist. Please refer to the provider directory for a complete listing of Guardian's contracted Dentists. Or You may access our website at dentalexchange.guardiandirect.com to view Guardian contracted Dentists. Please check with Your Guardian Dentist to verify that Your plan is accepted.

Changing Your Dentist

You can choose any Guardian contracted provider at any time. If You wish to change Dentists, please review Guardian's provider directory for Dentists in Your area and call to schedule an appointment. You may also call the 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 Guardian 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 dentalexchange.guardiandirect.com

Notice of Claim

Written notice of claim must be given to Guardian 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 written notice of claim by You, Guardian 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 as to proof of loss upon submitting, within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Guardian 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 Guardian, 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.

Alternative Dental Treatment

If Guardian 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, Guardian may request x-rays and any other appropriate information from the Dentist.

GENERAL PROVISIONS

Assignment

Your rights and benefits under this Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment. Upon receipt of a Covered Service, You may assign dental insurance benefits to the Dentist providing such service. If You assign payment of dental insurance to the Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay dental insurance benefits to You.

Recovery of Overpayments

Guardian has the right to recover any amount it determines to be an overpayment for services received. An overpayment occurs if Guardian determines that the total amount paid by Guardian 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 Guardian;
- 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 three (3) 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.

Clean Claim is a claim received by Guardian 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 Guardian 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 Guardian 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.

Grace Period means the period of time immediately following the premium due date which Your financial obligation can be met without penalty or cancellation.

Preferred Provider means a Dentist or dental care facility that is under contract with Guardian and has a contractual agreement with Guardian 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 Guardian.

We means The Guardian Life Insurance Company (“Guardian”).

You or Your means the insured Employee.