The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information and the date these benefits take effect. This schedule lists the services available under the Policy, as well as deductibles, benefit maximum amounts, coinsurance percentages, frequency limitations and exclusions. Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICY BENEFITS

Your Benefit Year is the 12 month period which starts on Your Policy Effective Date and ends on the 12th month of each year.

A covered person may receive dental treatment from any Dentist he or she chooses. This Policy usually pays a higher level of benefits for covered treatment furnished by a Contracted Dentist. Conversely, it usually pays less for covered treatment furnished by a Non-Contracted Dentist.

Dentists who are contracted in Guardian's network have agreed to accept a discount for the Covered Services they perform. When You visit one of these Dentists, the discount will lower Your out-of-pocket costs. When You visit a Non-Contracted dentist, Your reimbursement will be based on Guardian's fee schedule for Your specific Policy for the Dentist's zip code.

BENEFIT YEAR INDIVIDUAL DEDUCTIBLE

Contracted Dentist:

Preventive Services	None
Basic Services	$50
Major Services	$50

Non-Contracted Dentist:

Preventive Services	$50
Basic Services	$50
Major Services	$50

COINSURANCE PERCENTAGES

Contracted Dentist:

Preventive Services	100%
Basic Services	70%
Major Services	50%
Orthodontic Services	50%

Non-Contracted Dentist:

Preventive Services	100%
Basic Services	70%
Major Services	50%
Orthodontic Services	50%

BENEFIT MAXIMUM AMOUNTS

Graded Benefit Year Maximum ……...Year 1 - $1000, Year 2 - $1250, Year 3 - $1500
Lifetime Maximum for Implants ……..…. $1000
Benefit Year Maximum for Orthodontics ……..... $500
Lifetime Maximum for Orthodontics ……..….$1000

Graded Benefit Year Maximum

This Policy applies a Graded Benefit Year Maximum. The Year 1 maximum amount applies during the first 12 months the covered person becomes insured for dental benefits under this Policy. The Year 2 maximum amount applies during the second 12 month period. The Year 3 maximum amount applies during the third 12 month period and each 12 month period thereafter.

The covered person must have a covered Preventive Service performed during the Benefit Year to move to the next maximum level. If the covered person does not have a covered Preventive Service Performed within the Benefit Year, the maximum amount will not be increased.

SERVICE WAITING PERIODS

You and Your dependents are eligible under this Policy after You complete the service benefit waiting period.

Preventive Services …… None
Basic Services …… 6 months
Major Services …….. 12 months
Implant Services ……... 12 months
Orthodontic Services …….. 12 months

LIST OF COVERED DENTAL SERVICES

The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.

PREVENTIVE SERVICES

Office Visits, Oral Evaluations

Office visits, oral evaluations, limited oral evaluations or limited problem focused re-evaluations: Limited to 1 in a 6 month period.

Comprehensive oral evaluation: Limited to 1 in a 36 month period, per Dentist.

After Hours Office Visits, Emergency Palliative Treatment

After-hours office visit or emergency palliative treatment: Limited to 1 in a 6 month period. Covered when no other treatment, other than radiographs, is performed in the same visit.

Radiographic Images

Complete series or panoramic radiographic images: Limited to 1 in a 60 month period. A complete series includes at least 14 images including bitewings.

Bitewing images: Limited to either a maximum of 4 bitewing images or vertical bitewing images, in a visit, once in a 12 month period.

Intraoral periapical images or occlusal images.

Prophylaxis

Prophylaxis: Limited to 1 prophylaxis or periodontal maintenance (considered a Periodontic Service) in a 6 month period.

Medically necessary prophylaxis: Limited to 1 in a 12 month period. Covered when needed due to a medical condition. Written verification from the medical physician is required.

Fluoride Treatment

Topical application of fluoride: Limited to covered persons under age 19. Limited to 1 in a 6 month period.

Sealants

Sealants or preventive resin restorations: Limited to covered persons under age 16. Limited to 1 per tooth in a 36 month period. Coverage is limited to permanent, unrestored molar teeth.

Space Maintainers

Space maintainers: Limited to covered persons under age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Limited to a maximum of 1 bilateral per arch or 1 unilateral per quadrant, per lifetime. Allowance includes all adjustments in the first 6 months.

Recementation of space maintainer: Covered if performed more than 12 months after the initial insertion.

Removal of fixed space maintainer: Limited to once per quadrant or arch per lifetime.

Minor Treatment to Control Harmful Habits

Fixed and removable Appliance therapy to control thumb sucking: Limited to covered persons under age 14. Limited to the initial Appliance. Allowance includes all adjustments in the first 6 months.

BASIC SERVICES

Diagnostic Services

Accession of tissue: Covered if performed in conjunction with a biopsy. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy services: Limited to covered persons age 40 and older. Limited to 1 test in a 24 month period.

Diagnostic casts: Covered when needed to prepare a treatment plan for 3 or more of the following services performed at the same time in more than 1 arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays; (5) implants.

Diagnostic consultation with a Dentist other than the one providing treatment: Limited to 1 per dental specialty in a 12 month period. Covered when no other treatment, other than radiographs, is performed during the visit.

Restorative Services

Amalgam restorations: Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing restorations will be considered for payment if 12 months have passed since the previous restoration was placed if the covered person is under age 19, and 36 months if the covered person is age 19 or older. 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. Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing restorations will be considered for payment if 12 months have passed since the previous restoration was placed if the covered person is under age 19, and 36 months if the covered person is age 19 or older. 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 1 per tooth in a 24 month period. Considered a temporary or provisional service 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 in conjunction with a permanent amalgam or resin restoration.

Non-Surgical Extractions

Extraction erupted tooth or exposed root: Allowance includes the treatment plan, local anesthetic and post-treatment care.

Adjunctive General Services

Injectable antibiotics needed solely for treatment of a dental condition.

MAJOR SERVICES

Crowns

Crowns: Covered when needed because of decay or Injury and only when the tooth cannot be restored with amalgam or resin based composite filling material. Limited to permanent teeth. Porcelain is not covered on molar teeth. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Dental Prosthesis replacement limitation applies. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

Inlays, Onlays, Labial Veneers

Inlays: An alternate benefit of an amalgam or resin-based composite restoration will be considered.

Onlays: Covered when needed because of decay or Injury and only when the tooth cannot be restored with amalgam or resin based composite filling material. Limited to permanent teeth. Porcelain is not covered on molar teeth. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Dental Prosthesis replacement limitation applies. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

Labial veneers: Limited to permanent Anterior and bicuspid teeth. Covered when needed because of decay or Injury and only when the tooth cannot be restored with amalgam or resin based composite filling material. Dental Prosthesis replacement limitation applies. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

Post and Core, Core Buildup

Post and core, core buildup: Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth. Dental Prosthesis replacement limitation applies.

Prosthodontic Services

Dentures, complete and partial: Limited to permanent teeth. Dental Prosthesis replacement limitation and missing tooth provision applies. Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures and interim dentures older than one year are considered to be a permanent Dental Prosthesis.

Fixed partial denture retainer crowns and pontics (bridge): Each retainer crown and each pontic make up a unit in a bridge. Limited to permanent teeth. Porcelain is not covered on molar teeth. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Dental Prosthesis replacement limitation and missing tooth provision apply. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

Implant/abutment supported crown or retainer for fixed partial denture: Limited to permanent teeth. Porcelain is not covered on molar teeth. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Dental Prosthesis replacement limitation and missing tooth provision apply.

Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch: Limited to permanent teeth. Dental Prosthesis replacement limitation and missing tooth provision apply.

Implant Services

Radiographic/surgical implant index, by report: Limited to once per arch in a 24 month period.

Surgical placement of implant: Limited to the replacement of permanent teeth. Dental Prosthesis replacement limitation and missing tooth provision apply. Allowance includes the treatment plan, local anesthetic and post-surgical care.

Prefabricated abutment, Custom fabricated abutment: Dental Prosthesis replacement limitation and missing tooth provision apply.

Bone replacement graft for ridge preservation, per site: Limited to once per tooth. Covered when done in conjunction with a covered surgical placement of an implant in the same site.

Repair implant supported prosthesis.

Repair implant abutment.

Implant removal.

Repairs and Maintenance of Dental Prostheses

Crown repair, bridge repair.

Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge: Covered if performed more than 12 months after initial insertion.

Denture repairs.

Adding teeth to partial dentures: Covered if replacing extracted natural teeth. Missing tooth provision applies.

Denture rebase: Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Covered if performed more than 12 months after the insertion of the denture. Limited to once per denture in a 24 month period.

Denture reline: Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Covered if performed more than 12 months after the insertion of the denture. Limited to once per denture in a 24 month period.

Denture adjustments: Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Covered if performed more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to 1 treatment, per arch, in a 12 month period.

Endodontic Services

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

Pulp cap - direct, pulp cap - indirect: Limited to permanent teeth and limited to 1 pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.

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

Root canal/endodontic therapy.

Retreatment of previous root canal therapy: Limited to once per tooth.

Apicoectomy: Limited to once per root.

Root Amputation: Limited to once per root.

Retrograde Filling: Limited to once per root.

Apexification.

Hemisection: Limited to once per tooth.

Periodontic Services

Non-surgical periodontics: Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probings of each tooth involved.

Periodontal maintenance: Limited to 1 periodontal maintenance or prophylaxis in a 6 month period.

Periodontal scaling and root planing: Limited to once per quadrant in a 24 month period. Covered when there is radiographic image and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once per lifetime.

Periodontic Surgical Services

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.

Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening: Limited to a total of 1 service, per tooth, in a 12 month period.

Gingivectomy or gingivoplasty (4 or more teeth per quadrant), osseous surgery, gingival flap procedure, distal or proximal wedge, or surgical revision procedure: Limited to a total of 1 service, per quadrant, in a 36 month period.

Tissue grafts: Limited to a total of 1 graft, per tooth or site, in a 36 month period. Covered when the tooth is present or when dentally necessary as part of a covered surgical placement of an implant.

Guided tissue regeneration: Limited to once per area or tooth, when the tooth is present.

Bone replacement graft: Limited to once per area or tooth, when the tooth is present.

Periodontic Related Services

Occlusal adjustment – limited: Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of 2 adjustments.

Occlusal guard: Covered when done within 6 months after osseous surgery. Limited to 1 per lifetime.

Oral and Maxillofacial Surgery

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

Surgical removal of erupted teeth, removal of impacted teeth, surgical removal of residual tooth roots.

Incisional biopsy of oral tissue.

Brush biopsy.

Alveoloplasty.

Vestibuloplasty.

Surgical excision of lesions.

Removal of exostosis.

Incision and drainage of abscess.

Frenulectomy.

Anesthesia

General anesthesia/deep sedation, intravenous moderate (conscious) sedation, non-intravenous (conscious) sedation, inhalation of nitrous oxide: Covered in conjunction with covered surgical services.

ORTHODONTIC SERVICES

This Policy provides benefits for orthodontic services for covered dependent children who are under 19 years old when the active orthodontic appliance is first placed.

Limited orthodontic treatment, interceptive orthodontic treatment, comprehensive orthodontic treatment: Coverage includes treatment plan and records, including initial, interim and final records.

Coverage also includes fabrication and insertion of Appliances, periodic visits, orthodontic retention and related visits.

Surgical placement of temporary anchorage device.

Transseptal fiberotomy.

How orthodontic benefits are paid

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) 24 months.

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 Policy.

We don't pay for orthodontic charges incurred by a covered person prior to being covered by this Policy. Based on the original treatment plan, We determine the portion of charges incurred prior to being covered by this Policy and deduct them from the total charges. What we pay is based on the remaining charges.

Orthodontic treatment performed by a Contracted Dentist

The negotiated discounted fees for orthodontics performed by a Contracted Dentist include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention and related visits; (c) limited, interceptive and comprehensive orthodontic treatment; (d) fabrication and insertion; and (d) periodic visits.

There is a separate negotiated discounted fee for orthodontic treatment which extends beyond 24 consecutive months.

The contracted fee for orthodontics performed by a Contracted Dentist does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) services, 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 Policy.

DENTAL PROSTHESIS REPLACEMENT LIMITATION

We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the covered person's mouth in an Injury suffered while covered and cannot be made serviceable.

MISSING TOOTH PROVISION

A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under 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 service or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) tobacco counseling; or (3) nutritional counseling.
- Duplication of radiograph images, the completion of claim forms, OSHA or other infection control charges.
- Any service performed in conjunction with, as part of, or related to a service which is not covered by this Policy.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a Dental Prosthesis; (2) bleaching of discolored teeth; and (3) odontoplasty.
- The replacement of extracted or missing third molars (wisdom teeth).
- Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth.
- Detailed and extensive oral evaluations.
- Cephalometric radiographic images.
- Oral /facial photographic images.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- 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.
- Implants and any service associated with the placement, prosthodontic restoration or maintenance of a dental implant unless this Policy provides specific benefits for implant treatment.
- Overdentures and related services including root canal therapy on teeth supporting an overdenture.
- Precision attachments.

- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures (stayplates) to replace Anterior Teeth extracted while covered under this Policy.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of a crown and/or bridge, per tooth.
- Any service performed on a tooth or teeth with a guarded, questionable or poor prognosis.
- Any restoration, service, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- Tooth re-implantation or tooth transplantation.
- Any service, Appliance, Dental Prosthesis, modality or surgical service intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to, or result from, a medical condition unless required due to state law.
- Orthodontic treatment, unless the Policy provides specific benefits for orthodontic treatment.
- Separate charges for local anesthetic.
- Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Bite registration, bite analysis or occlusion analysis – mounted case.
- Prescription medication.