Dental Plans

Option 1: Managed Dental Care plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.
Option 2 or 3: BASE or BUY-UP plan, you'll have access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when they belong to a tier in the Tier 1 reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**Option 1: Managed Dental Care**	**Option 2: BASE**		**Option 3: BUY-UP**	
Network	Managed Dental Care	DentalGuard Preferred Network		DentalGuard Preferred Network	
		Tier 1	Tier 2	Tier 1	Tier 2
		In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar year deductible		*Tier 1*	*Tier 2*	*Tier 1*	*Tier 2*
Individual	No deductible	$50	$50	$50	$50
Family limit		3 per family (applies to all levels)		3 per family (applies to all levels)	
Waived for		Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*Network only*	*Tier 1*	*Tier 2*	*Tier 1*	*Tier 2*
Preventive Care	You pay a copay for each	100%	80%	100%	80%
Basic Care	covered procedure. See	80%	80%	80%	80%
Major Care	"Plan Details", for	50%	50%	50%	50%
Orthodontia	more information.	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit		$2000 (applies to all levels)		$2500 (applies to all levels)	
Maximum Rollover	Maximum Rollover is not	Yes (applies to all levels)		Yes (applies to all levels)	
Rollover Threshold	applicable for this plan type.	$800		$900	
Rollover Amount		$400		$450	
Rollover In-network Amount		$600		$700	
Rollover Account Limit		$1500		$1500	
Lifetime Orthodontia Maximum	Not Applicable	Not Applicable (applies to all levels)		$2000 (applies to all levels)	
Office visit copay	$5	None (applies to all levels)		None (applies to all levels)	
Dependent Age Limits	26	26 (applies to all levels)		26 (applies to all levels)	

YOUR GUARDIAN PLAN OFFERS:

If you enroll in Dental, you receive a Vision Access Plan at no additional charge. Visit any network doctor in your Access Plan and you'll receive discounts on exams, glasses, contact lens professional services and laser vision surgery.

Maximum rollover If a member submits at least one claim and stays under the claims threshold, a part of the unused maximum will be rolled over for use in future years.

Great selection of dentists convenient to you - yours is likely in our network!

Reliable claims payment four days on average

Find out if your dentist is in Guardian's network at www.Guardianlife.com

Let Guardian put its 30-plus years of dental benefits experience to work for you and your family.

CATEGORY	PLAN DETAILS	Option 1: Managed Dental Care	Option 2: BASE		Option 3: BUY-UP	
		You Pay	*Plan pays (on average)*		*Plan pays (on average)*	
		Network only				
			Tier1	Tier 2	Tier1	Tier 2
Preventive Care	Cleaning (prophylaxis)	$0	100%	80%	100%	80%
	Frequency:	2 in 12 months	Once Every 6 Months (applies to all levels)		Once Every 6 Months (applies to all levels)	
	Fluoride Treatments	$0	100%	80%	100%	80%
	Limits:	Under Age 18	Under Age 14 (applies to all levels)		Under Age 14 (applies to all levels)	
	Oral Exams	$0	100%	80%	100%	80%
	Sealants (per tooth)	$0	100%	80%	100%	80%
	X-rays	$0	100%	80%	100%	80%
Basic Care	Anesthesia*	Not Covered	80%	80%	50%	50%
	Fillings‡	$0	80%	80%	80%	80%
	Perio Surgery	$95	80%	80%	80%	80%
	Periodontal Maintenance	$0	80%	80%	80%	80%
	Frequency:	Once every 3 to 6 months (Standard)	Once Every 6 Months (applies to all levels)		Once Every 6 Months (applies to all levels)	
	Repair & Maintenance of Crowns, Bridges & Dentures	$0	80%	80%	50%	50%
	Root Canal	$0-90	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	$0	80%	80%	80%	80%
	Simple Extractions	$0	80%	80%	80%	80%
Major Care	Bridges and Dentures	$110-130	50%	50%	50%	50%
	Dental Implants	Not Covered	50%	50%	50%	50%
	Inlays, Onlays, Veneers**	$40-80	50%	50%	50%	50%
	Single Crowns	$90	50%	50%	50%	50%
	Surgical Extractions	$25-40	50%	50%	50%	50%
Orthodontia	Orthodontia	$1,975-2,175	Not Covered		50%	50%
	Limits:	Adults & Child(ren)	(applies to all levels)		Adults & Child(ren) (applies to all levels)	

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation. This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia - restrictions apply. ‡For PPO and or Indemnity members, Fillings-restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Please note: The plan details listed here are some of the most common services related to dental coverage. The co-insurance percentages for the PPO plan options correspond to the coverage categories of Preventive, Basic, Major and Orthodontia listed in the table above.

Some services may be paid under a different category than listed. The actual co-insurance shown reflects your plan's coverage.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # DG7-P et al.
- This policy provides dental coverage only. This policy provides managed care dental benefits through a network of participating general dentists and specialty care dentists. Except for limited emergency services, benefits will be provided for services provided by the primary care dentist selected by the member. The member must pay the primary care dentist a patient charge/copayment for most covered services. No benefits will be paid for treatment by a specialist unless the patient is referred by his or her primary care dentist and the referral is approved under the policy. Only those services listed in the policy's schedule of benefits are covered. Certain services are subject to frequency or other periodic limitations. Where orthodontic benefits are specifically included, the policy provides for one course of comprehensive treatment per member. Unless specifically included, the Managed Dental Care policy does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed Dental Care policy. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The applicable Managed Dental Care documents are the final arbiter of coverage .See your Certificate for complete specifics of all Exclusions and Limitations. All products, unless otherwise noted, are underwritten by The Guardian Life. Insurance Company of America ("Guardian") or one of the following wholly-owned Guardian subsidiaries: Managed Dental Care (CA); First Commonwealth Insurance Company (IL); First Commonwealth Limited Health Services Corporation (IN); First Commonwealth Limited Health Services Corporation of Michigan (MI); First Commonwealth of Missouri, Inc. (MO) and Managed DentalGuard, Inc. (NJ, OH and TX). Any reference to a specific product type, including but not limited to "DHMO" or "Prepaid" is not intended to refer to a specific state license designation, but rather is merely intended to refer to a general product design. Such DHMO, or prepaid products, are licensed in the applicable jurisdiction. In addition, certain products are underwritten by Dominion Dental Services, Inc. (DC, DE, MD, PA and VA) and LIBERTY Dental Plan of Nevada, Inc. (NV) and Total Dental Administrators Health Plan, Inc. (AZ). Please see the applicable policy forms for details. In the event of conflict between this brochure and the policy forms, the policy forms shall control.

Managed DentalGuard

Plan Schedule – 90M

MDG Codes ++	Covered Services	Patient Charges
	Appointments & Diagnostic Services	
0101*	Office visit - during regular hours - participating general dentist only	$5.00
0102	Broken appointment (without 24 hours notice)	$25.00
0120/0140/0150	Oral evaluation	NO CHARGE
0460	Pulp vitality tests	NO CHARGE
0470	Diagnostic casts	NO CHARGE
9310	Consultation (by dentist other than practitioner providing treatment)	NO CHARGE
9430	Office visit for observation - regular hours - no other service performed	NO CHARGE
9440	Emergency office visit - after regularly scheduled office hours	$50.00
	Radiographs	
0210	Intraoral - complete series (including bitewings)	NO CHARGE
0220/0230/0240	Intraoral - periapical or occlusal - single film	NO CHARGE
0270/0272/0274	Bitewings	NO CHARGE
0330	Panoramic film	NO CHARGE
	Preventive & Space Maintenance	
1110/1120	Prophylaxis	NO CHARGE
1201/1203	Topical application of fluoride (may include prophylaxis) - child	NO CHARGE
1310	Nutritional counseling for control of dental disease	NO CHARGE
1330	Oral hygiene instruction	NO CHARGE
1351	Sealant - per tooth	NO CHARGE
1510	Space maintainer - fixed - unilateral	NO CHARGE
1515	Space maintainer - fixed - bilateral	NO CHARGE
1550	Recementation of space maintainer	NO CHARGE
	Restorative	
2110	Amalgam - one surface - primary	NO CHARGE
2120	Amalgam - two surfaces - primary	NO CHARGE
2130	Amalgam - three surfaces - primary	NO CHARGE
2131	Amalgam - four or more surfaces - primary	NO CHARGE
2140	Amalgam - one surface - permanent	NO CHARGE
2150	Amalgam - two surfaces - permanent	NO CHARGE
2160	Amalgam - three surfaces - permanent	NO CHARGE
2161	Amalgam - four or more surfaces - permanent	NO CHARGE
2210	Silicate cement - per restoration	NO CHARGE
2330	Resin/composite - one surface, anterior	NO CHARGE
2331	Resin/composite - two surfaces, anterior	NO CHARGE
2332	Resin/composite - three surfaces, anterior	NO CHARGE
2335	Resin/composite - four or more surfaces or incisal angle, anterior	NO CHARGE
2336	Composite resin crown, anterior - primary	NO CHARGE
2380	Resin/composite - one surface, posterior - primary	NO CHARGE
2381	Resin/composite - two surfaces, posterior - primary	NO CHARGE
2382	Resin/composite - three or more surfaces, posterior - primary	NO CHARGE
2385	Resin/composite - one surface, posterior - permanent	NO CHARGE
2386	Resin/composite - two surfaces, posterior - permanent	NO CHARGE
2387	Resin/composite - three or more surfaces, posterior – permanent	NO CHARGE

MDG Codes ++	Covered Services	Patient Charges
	Crown, Bridge & Other Cast Restorations	
2510	Inlay - metallic - one surface**	$60.00
2520/6520	Inlay - metallic - two surfaces**	$75.00
2530/6530	Inlay - metallic - three or more surfaces**	$75.00
2543/6543	Onlay - metallic - three surfaces**	$80.00
2544/6544	Onlay - metallic - four or more surfaces**	$80.00
2702	Crown supporting existing partial denture, in addition to crown	$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	$125.00
2740	Crown - porcelain/ceramic substrate	$100.00
2750 - 2752	Crown - porcelain fused to metal**	$95.00
2790 - 2792	Crown - full cast metal**	$90.00
2810/6780	Crown - 3/4 cast metallic**	$95.00
6210 - 6212	Pontic - cast metal**	$90.00
6240 - 6242	Pontic - porcelain fused to metal**	$95.00
6750 - 6752	Crown - abutment - porcelain fused to metal**	$95.00
6790 - 6792	Crown - abutment - full cast metal**	$90.00
	Other Restorative Services	
2910/2920/6930	Recement inlay, crown, bridge	NO CHARGE
2930/2931	Prefabricated stainless steel crown	$10.00
2932	Prefabricated resin crown	$20.00
2940	Sedative filling	NO CHARGE
2950/6973	Core buildup, including any pins	$20.00
2951	Pin retention - per tooth, in addition to restoration	NO CHARGE
2952/6970	Cast post & core	$30.00
2954/6972	Prefabricated post & core	$25.00
2960	Labial veneer (laminate) – chairside	$40.00
	Endodontics	
3110/3120	Pulp cap	NO CHARGE
3220	Therapeutic pulpotomy	NO CHARGE
3310	Root canal – anterior	NO CHARGE
3320	Root canal – bicuspid	NO CHARGE
3330	Root canal – molar	$90.00
3346	Root canal - retreatment – anterior	NO CHARGE
3347	Root canal - retreatment – bicuspid	NO CHARGE
3348	Root canal - retreatment - molar	$95.00
3410	Apicoectomy/periradicular surgery - anterior	$55.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	$60.00
3425	Apicoectomy/periradicular surgery – molar - first root	$60.00
3426	Apicoectomy/periradicular surgery – each additional root	$25.00
3430	Retrograde filling - per root	$10.00
	Periodontics	
4210	Gingivectomy or gingivoplasty - per quadrant	$35.00
4211	Gingivectomy or gingivoplasty - per tooth	$15.00
4240	Gingival flap procedure - including root planing - per quadrant	$65.00
4249	Clinical crown lengthening - hard tissue	$55.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	$95.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	$60.00

Managed DentalGuard

Plan Schedule – 90M

MDG Codes ++	Covered Services	Patient Charges
	Periodontics (cont.)	
4270	Pedicle soft tissue graft procedure	$65.00
4271	Free soft tissue graft procedure (including donor site surgery)	$70.00
4341	Periodontal scaling & root planing – per quadrant	NO CHARGE
4355	Full mouth debridement to enable evaluation & diagnosis	NO CHARGE
4910	Periodontal maintenance procedures (following active therapy)	NO CHARGE
4920	Unscheduled dressing change (by other than treating dentist)	NO CHARGE
9951	Occlusal adjustment - limited - per visit	NO CHARGE
	Prosthodontics (Removable)	
5110/5120	Complete denture (including routine post delivery care)	$110.00
5130/5140	Immediate denture (including routine post delivery care)	$110.00
	Partial dentures (including routine post delivery care):	
5211/5212	Resin base - including clasps, rests, teeth	$90.00
5213/5214	Cast metal framework with resin base - including clasps, rests, teeth	$130.00
	Repairs & adjustments:	
5410/11/21/22	Denture adjustments	$5.00
5510/5610	Repair denture base	NO CHARGE
5520/5640	Replace missing or broken teeth – per tooth	NO CHARGE
5630	Repair or replace clasp	NO CHARGE
5650	Add tooth to existing partial	NO CHARGE
5660	Add clasp to existing partial	NO CHARGE
5710/11/20/21	Rebase denture	NO CHARGE
5730/31/40/41	Reline denture (chairside)	NO CHARGE
5750/51/60/61	Reline denture (laboratory)	NO CHARGE
5820/5821	Interim partial denture (stayplate)	$45.00
5850/5851	Tissue conditioning	NO CHARGE
	Oral Surgery	
7110/7120	Extraction - single tooth	NO CHARGE
7130	Root removal - exposed roots	NO CHARGE
7210	Surgical removal of erupted tooth	$20.00
7220	Removal of impacted tooth - soft tissue	$25.00
7230	Removal of impacted tooth - partially bony	$35.00
7240	Removal of impacted tooth - completely bony	$40.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$40.00
7250	Surgical removal of residual tooth roots (cutting procedure)	$20.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	$30.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	$45.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$30.00
7285	Biopsy of oral tissue - hard	$25.00
7286	Biopsy of oral tissue - soft	$20.00
7310	Alveoplasty in conjunction with extractions - per quadrant	$15.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	$25.00
7450	Removal of odontogenic cyst/tumor – up to 1.25cm	$30.00
7451	Removal of odontogenic cyst/tumor – over 1.25cm	$55.00
7470	Removal of exostosis - maxilla or mandible	$40.00
7510	Incision & drainage of intraoral abscess	$15.00
7960	Frenulectomy (separate procedure)	$30.00
	Orthodontic Treatment (covers 24 months active treatment)	
8601	Orthodontic evaluation and consultation	$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and photos	$150.00
8070/8080/8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months; dependent child to age 18 (as determined by the Member's age on the date of banding)	$1975.00
8070/8080/8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months; employee, spouse, or dependent child over age 18 (as determined by the Member's age on the date of banding)	$2175.00
8670	Periodic comprehensive orthodontic treatment visit	NO CHARGE
8680	Orthodontic retention	$300.00
	Miscellaneous Services	
9110	Palliative (emergency) treatment - per visit	NO CHARGE
9215	Local anesthesia	NO CHARGE

++ Covered Services are subject to exclusions, limitations and Plan provisions. Other codes may be used to describe Covered Services.

** If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

▪ Plan Schedules are only Valid for Covered Services rendered by Participating Dentists in the State of California.