

Dental Plans

COMPARE YOUR PLANS

Option 1: With your **Pre-Paid** 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: With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

COMPARE THE PLANS	Option 1: Pre-Paid	Option 2: PPO	
Calendar year deductible		<i>In-network</i>	<i>Out-of-network</i>
Individual	No deductible	\$50	\$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	<i>Network only</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care (e.g., cleanings)	You pay a copay for each covered procedure. See	100%	100%
Basic Care (e.g., fillings, extractions)	covered procedure. See	90%	80%
Major Care (e.g., crowns, dentures)	"Plan Details", over, for	60%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	\$2000	\$1500
		Combined In-Network and Out-of-Network maximum of \$2000 with Out-of-Network benefits limited to \$1500	
Lifetime Orthodontia Maximum	Not Applicable	\$1000	
Office visit copay	\$5	None	
Monthly switch	Yes	Yes	
Network	Managed DentalGuard	DentalGuard Preferred	

YOUR GUARDIAN PLAN OFFERS:

Family coverage for spouse and children to age 20 (26 if full-time student)

Coverage of ViziLite Plus early cancer detection screening exams

Monthly Switch between plans for you and your family if you request a switch by the 20th of any month.

National PPO network of more than 70,000 dentist locations

Plan coverage begins January 01, 2009

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

Switch Plans with one call

If your needs change, you can switch to the other plan with a phone call. Your switch becomes effective the first day of the next month if requested by the 20th of the month, and applies to your whole family (if you have family coverage).

CATEGORY	PLAN DETAILS	Option 1: Pre-Paid	Option 2: PPO	
		You Pay	Plan pays (on average)	
		Network only	In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	\$0	100%	100%
	Frequency:	4 times in 12 Months	Once Every 6 Months	
	Fluoride Treatments	\$0	100%	100%
	Limits:	No Age Limits	No Age Limits	
	Oral Exams	\$0	100%	100%
	Periodontal Maintenance	\$0	100%	100%
	Frequency:	4 times in 12 months (Standard)	Once Every 3 Months (Enhanced)	
	Sealants (per tooth)	\$0	100%	100%
X-rays	\$0	100%	100%	
Basic Care	Anesthesia*	Restrictions Apply	90%	80%
	Fillings (one surface)†	\$0	90%	80%
	Perio Surgery	\$200-380	90%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	\$0-160	90%	80%
	Root Canal	\$120-270	90%	80%
	Scaling & Root Planing (per quadrant)	\$0	90%	80%
	Simple Extractions	\$0	90%	80%
	Surgical Extractions	\$30-200	90%	80%
Major Care	Bridges and Dentures	\$381-575	60%	50%
	Dental Implants	Not Covered	60%	50%
	Inlays, Onlays, Veneers**	\$250-370	60%	50%
	Single Crowns	\$395	60%	50%
Orthodontia	Orthodontia	\$1,500-2,800	50%	50%
	Limits:	Child(ren)	Adults & Child(ren)	
Cosmetic Care	Bleaching	\$165	Not Covered	Not Covered

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.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury and only when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age of 19; full-time student age does not apply to the initial placement of the appliance. 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. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia—Restrictions apply & may be subject to medical necessity. †Silver fillings and white fillings for front teeth. Other types of fillings may be paid at other benefit levels.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred 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, 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 # GP-1-DG2000 et al.
- Important information about Guardian's Managed DentalGuard Pre-Paid (Florida) Plan, Managed Dental Care's DHMO (California) Plan and Managed DentalGuard, Inc.'s Managed DentalGuard DHMO (Texas) Plan: This plan provides pre-paid dental benefits through a network of participating general dentists and specialty care dentists. All covered services must be provided by the member's Primary Care Dentist. Specialty care services are covered only when referred by the member's

- Primary Care Dentist and approved in advance by Managed DentalGuard. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. Unless specifically included, the Managed DentalGuard plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed DentalGuard plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed DentalGuard plan documents are the final arbiter of coverage. GP-1-MDG1, et al. or GP-1-MDG-FL-1-08, et al. (Florida), GP-1MDC1, et al. or GP-1-MDC-CA-1-08, et al. (California), GP-1-MDG-TX1, et al. or GP-1-MDG-TX-1-08, et al. (Texas), GP-1-MDG-NY1, et al. or GP-1-MDG-NY-1-08, et al. (New York), GP-1-MDG-1-NJ, et al. or GP-1-MDG-NJ-1-08, et al. (New Jersey)
- **Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

UNDERSTANDING YOUR BENEFITS—DENTAL

Basic care	Moderately complex dental services. Most plans consider fillings and extractions to be basic care.
Co-insurance	The portion of the covered charge paid by Guardian.
Copay (short for copayment)	A fixed fee paid to a dentist at the time a dental service is performed. Some sample copays are shown in this booklet. A complete list is shown in your certificate booklet.
Deductible	The amount of charges you and your family must pay each plan year before the plan pays you any benefits.
Dental office number	The unique identification number assigned to a dental provider. Each family member must select a primary care dentist and enter his or her number on the enrollment form.
Pre-Paid Plan	A plan that requires you to visit a network dentist. You pay a fixed copay to the dentist for each service performed. No benefits are available for services of dentists who are not in the network.
Family limit	Maximum number of deductibles your family must pay in each plan year before this plan starts paying benefits for all covered family members for the rest of the plan year.
In-network charges	Charges for services provided by dentists who are a member of your plan's network.
Major care	More complex dental services. Most plans consider crowns and dentures to be major care.
Out-of-network charges	Charges for services provided by dentists who are not members of your plan's network.
Plan year	The 12 month period used to apply this plan's deductible and annual maximum. Your plan's plan year is the calendar year.
PPO (Preferred Provider Organization)	Plan that lets you visit any dentist, but usually provides better benefits for the services of PPO network dentists. PPO dentists have agreed to accept discounted fees as payment in full.
Preventive care	Most routine dental services. Most plans consider checkups and cleanings to be preventive care.
UCR (Usual and Customary Rate)	PPO & NAP The usual cost for a specific dental service in your area. Amounts over the specified UCR percentile (90%) are usually the patient's responsibility: In-Network: Benefits are based on a negotiated contracted fee schedule, and no balance billing. Out-of-Network: Benefits are based on usual, reasonable, and customary rates for a given area.