

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

|  |                                |
|--|--------------------------------|
| Plan Name: QD without Ortho                    | Name of Product: DentalGuard   |
| Type or Product Line: DPPO                     | Plan Phone #: 1-888-Guardian   |
| Effective Date: Beginning on or after 1/1/2023 | Plan Website: guardianlife.com |

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT GUARDIANLIFE.COM OR CALL 1-888-GUARDIAN. THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

Part II: DEDUCTIBLES

|            |                      |                      |
|------------|----------------------|----------------------|
| Deductible | In-Network           | Out-of-Network       |
| Dental     | Per Individual \$ 50 | Per Individual \$ 50 |

**The deductible applies to all services except Preventive.**  
A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.  
**In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.  
**Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

|                |            |                |
|----------------|------------|----------------|
| Maximums       | In-Network | Out-of-Network |
| Annual Maximum | \$ 2,000   | \$ 1,500       |

**Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**  
**Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

**Waiting Periods:** A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **There is no waiting period.**

**Part V: WHAT YOU WILL PAY**

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

| Common Dental Procedures                           | Category    | In-Network                    | Out-of-Network                | Benefit Limitations and Exclusions   |
|--|-------------|-------------------------------|-------------------------------|--|
| <i>Oral Exam</i>                                   | Preventive  | 0%, deductible does not apply | 0%, deductible does not apply | 1 in 6 Months - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.                             |
| <i>Bitewing X-ray</i>                              | Preventive  | 0%, deductible does not apply | 0%, deductible does not apply |  |
| <i>Cleaning</i>                                    | Preventive  | 0%, deductible does not apply | 0%, deductible does not apply | 1 in 6 Months - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.                             |
| <i>Filling</i>                                     | Basic       | 10%                           | 20%                           |  |
| <i>Extraction, Erupted Tooth or Exposed Root</i>   | Basic       | 10%                           | 20%                           |  |
| <i>Root Canal</i>                                  | Basic       | 10%                           | 20%                           |  |
| <i>Scaling and Root Planing</i>                    | Basic       | 10%                           | 20%                           |  |
| <i>Ceramic Crown</i>                               | Major       | 40%                           | 50%                           |  |
| <i>Removable Partial Denture</i>                   | Major       | 40%                           | 50%                           |  |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Basic       | 10%                           | 20%                           |  |
| <i>Orthodontia</i>                                 | Orthodontia | 100%                          | 100%                          | Orthodontia is not covered under this plan. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations. |