Part I: GENERAL INFORMATION

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| Insurer Name:  The Guardian Life Insurance Company of America | Plan Name: Guardian Advantage Starter |
| Policy Type: PPO | Insurer Phone #: 1-866-569-9900 |
| Effective Date: Refer to your policy documents | Insurer Website: guardiandirect.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 INSURER WEBSITE AT guardiandirect.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 | Preventative Care $50; All other Dental Services $50 per individual | $50 per individual |

The deductible applies to / all services except Preventative Services.
A deductible is the amount you are required to pay for covered dental services each policy year before the insurer 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 insurer for alternative rates of payment for dental services.
Out-of-network services are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

| Maximums | In-Network | Out-of-Network |
|---|---|---|
| Annual Maximum | Graded Benefit Year Maximum: Year 1 -  $500, Year 2 - $750, Year 3 - $1000 | Yes, the cost-sharing will be higher. Contact your Plan. |
| Lifetime Maximum for Orthodontia | Not covered | Not covered |

Annual maximum is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
Lifetime maximum means the maximum dollar amount your policy 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 for all or certain dental treatments.
Preventative Services – None
Basic Services – 6 months

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 |
|---|---|---|---|---|
| Oral Exam | Preventative | $0, deductible does not apply | $0 | Office visits, oral evaluations, limited oral evaluations or limited problem focused re-evaluations: Limited to 1 in a 6 month period. Teledentistry evaluations: Up to $50.00 per covered service.  Comprehensive oral evaluation: Limited to 1 in a 36 month period, per Dentist. |
| Bitewing X-ray | Preventative | $0, deductible does not apply | $0 | Limited to either a maximum of 4 bitewing images or vertical bitewing images, in a visit, once in a 12-month period. |

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|---|---|---|---|---|
| Cleaning | Preventative | $0, deductible does not apply | $0 | Limited to 1 prophylaxis or periodontal maintenance (considered a Periodontic Service) in a 6 month period. |
| Filling | Basic | 50% after 6 months | 50% after 6 months | 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. |
| Simple Extraction | Basic | 50% after 6 months | 50% after 6 months | Extraction erupted tooth or exposed root: Allowance includes the treatment plan, local anesthetic, and post-treatment care. |
| Root Canal | Major | Not Covered | Not Covered | |
| Scaling and Root Planing | Major | Not Covered | Not Covered | |
| Ceramic Crown | Major | Not Covered | Not Covered | |
| Removable Partial Denture | Major | Not Covered | Not Covered | |
| Orthodontia | Major | Not Covered | Not Covered | |

Out of Network: Reimbursement is based on the lower of your dentist’s fees or the amount that would be paid to dentists who have agreed to be reimbursed according to our negotiated fee schedule.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

| Dana Has a Dental Appointment with a New Dentist | | Sam Needs a Tooth Filled | | Maria Needs a Crown | |
|---|---|---|---|---|---|
| New patient exam, x-rays (FMX) and cleaning | | Resin-based composite - one surface, posterior | | Crown - porcelain/ceramic substrate | |
| Dana's Visit | Dana's Cost | Sam's Visit | Sam's Cost | Maria's Visit | Maria's Cost |
| Total Cost of Care | In-network: $250 | Total Cost of Care | In-network: $150 | Total Cost of Care | In-network: $950 |
| | Out-of-network: $450 | | Out-of-network: $250 | | Out-of-network: $1,400 |
| Deductible | In-network: $0 | Deductible | In-network: $50 | Deductible | In-network: **N/A** |
| | Out-of-network: $50 | | Out-of-network: $50 | | Out-of-network: **N/A** |
| Annual Maximum (Plan Will Pay) | In-network: Year 1 - $500, Year 2 - $750, Year 3 - $1000 | Annual Maximum (Plan Will Pay) | In-network: Year 1 - $500, Year 2 - $750, Year 3 - $1000 | Annual Maximum (Plan Will Pay) | In-network: $0 |
| | Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. | | Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. | | Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. |
| Patient Cost (copayment or coinsurance) | In-network: 0% | Patient Cost (copayment or coinsurance) | In-network 50% | Patient Cost (copayment or coinsurance) | In-network: Not Covered |
| | Out-of-network: 0% | | Out-of-network: 50% | | Out-of-network: Not Covered |
| In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable): | In-network: $0 | In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable): | In-network: $100 | In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable): | In-network: $950 |
| | Out-of-network $50 | | Out-of-network $150 | | Out-of-network: $1400 |
| Summary of what is not covered or subject to a limitation: | Exams & Cleaning: Limited to 1 in a 6 month period.<br>Xrays: Limited to either a maximum of 4 bitewing images or vertical bitewing images, in a visit, once in a 12-month period. | Summary of what is not covered or subject to a limitation: | 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. | Summary of what is not covered or subject to a limitation: | N/A |