



Advanced Benefit Concepts, LLC

	Coinurance	Deductible	Waived for Preventive	Annual Maximum	Reimbursement
In-network	100/80/50	\$50	Yes	\$1,500	Fee Schedule
Out of Network	80/60/40	\$100	No	\$1,000	Fee Schedule

Plan Includes:

- Maximum Rollover
- 2 year rate guarantee
- White fillings covered
- Periodontics & Endodontics covered as a basic service
- National network with over 100,000 provider locations. Search for providers at www.guardianlife.com. (PPO DentalGuard Preferred network)

PENNSYLVANIA (Eastern)

Zip codes: 189-191, 193-194

2-9 Lives					10-15 Lives					16-24 Lives				
Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho
33.21	72.24	87.03	126.07	10.41	30.52	66.41	80.00	115.88	10.41	29.57	64.33	77.50	112.25	10.49

*Add the ortho rate to the EE/Child(ren) & Family Rate.

PENNSYLVANIA (Western)

Zip codes: 150-168

2-9 Lives					10-15 Lives					16-24 Lives				
Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho
28.90	64.06	77.37	112.53	10.41	26.02	57.66	69.65	101.29	11.36	24.58	54.58	65.81	95.71	10.49

*Add the ortho rate to the EE/Child(ren) & Family Rate.

NEW JERSEY

Zip codes: 070, 077, 080, 082, 085-087

2-9 Lives					10-15 Lives					16-24 Lives				
Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho
38.18	73.83	87.33	122.98	10.62	35.11	67.89	80.31	113.09	11.60	34.00	65.75	77.77	109.52	10.72

*Add the ortho rate to the EE/Child(ren) & Family Rate.

DELAWARE

Zip code: 199

2-9 Lives					10-15 Lives					16-24 Lives				
Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho	Employee	EE/Spouse	EE/Child(ren)	Family	Ortho
31.20	60.47	71.56	100.83	9.10	28.69	55.60	65.80	92.71	9.95	27.79	53.86	63.74	89.81	9.18

*Add the ortho rate to the EE/Child(ren) & Family Rate.

- Fluoride Treatment; every 6 months under age 14
- Oral Examination - every six months
- Space Maintainers for Children-under age 16
- Teeth Cleaning - every six months
- Topical Sealants-unrestored molar teeth - 1 treatment for child(ren) under 16 in a (3) year
- X-Rays - 4 bitewings every 12 months, full mouth every five years

- Diagnostic Consultation- one per year
- Repairs of dentures, bridgework, crowns
- General Anesthesia (surgical procedures only)
- Injectable Antibiotics- for treatment of a dental condition only
- Laboratory Test
- Oral Surgery
- Fillings: Composite, Anterior & Posterior
- Endodontic Services/Root Canal Therapy",0)
- Periodontal Services

- Crowns: Resin, Metal
- Dentures- Full and Partial
- Inlays
- Onlays
- Posts

SIC CODE INDUSTRY LOADS

Industry	SIC	% Load	Industry	SIC	% Load
Veterinary Services	074x	10%	Insurance & Real Estate	653x	6%
Automobile Sales & Services	55xx	5%	Entertainers	792x	50%
Government Employees	43xx, 93xx	10%	Sports Teams	7999	25%
Government Employees	92xx, 94xx - 96xx	5%	Dentists	802x	50%
Government Employees	97xx	8%	Legal Services	81xx	8%
Insurance & Real Estate	64xx	15%	Teachers	821x-822x, 82438,244, 824!	19%

IMPORTANT NOTES

- Rates valid for quotes presented between 10/1/2011 and 3/31/2012
- If there is an average of more than 4 children per dependent (EE+CH or FAM) unit, call your Guardian Sales Office for more information.
- Dependent children are covered up to age 20, or age 26 if full-time student.
- Child Ortho benefit is 50% to \$1,000 Lifetime maximum. Ortho requires that groups of 10-24 have a minimum of 4 child units and a 5-9 life group must have a minimum of 3 child units.
- Groups with 5-9 lives require a 12 month waiting period for Ortho coverage. The waiting period can be waived only for currently enrolled employees of a transferred group if child Ortho is in force with the prior plan. Child Ortho requires (3) family and/or parent/child(ren) units for groups of 5-9 & (4) family and/or parent/child(ren) units for groups of 10-24
- 65% Participation Requirement

DentalGuard Dental Insurance Plan General Limitations and Exclusions:

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), orthodontic (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. GP-1-DNTL-90-1 et al.