Dental Plans

Option 1: With your **DHMO 'U'** 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: DHMO 'U'	Option 2: PPO	
Network	First Commonwealth	DentalGuard Preferred	
Calendar year deductible		*In-Network*	*Out-Network*
Individual	No deductible	$50	$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-Network*
Preventive Care (e.g. cleanings)	You pay a copay for each	100%	100%
Basic Care (e.g. fillings)	covered procedure. See	80%	80%
Major Care (e.g. crowns, dentures)	"Plan Details", for	50%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	$1000	$1000
Maximum Rollover	Maximum Rollover is not	Yes	
Rollover Threshold	applicable for this plan type.	$500	
Rollover Amount		$250	
Rollover In-network Amount		$350	
Rollover Account Limit		$1000	
Lifetime Orthodontia Maximum	Not Applicable	$1000	
Office visit copay	$5	None	
Dependent Age Limits	26 ‡	26 ‡	

‡**Family coverage** for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.

YOUR GUARDIAN PLAN OFFERS:

Coverage of ViziLite Plus early cancer detection screening exams

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.

National PPO network of more than 70,000 dentist locations

Reliable claims payment four days on average

Plan coverage begins July 01, 2011

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: DHMO 'U' *You Pay*	Option 2: PPO *Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%
	Frequency:	2 times in 12 months^	Once Every 6 Months	
	Fluoride Treatments	$0-12	100%	100%
	Limits:	No Age Limits	Under Age 19	
	Oral Exams	$0	100%	100%
	Sealants (per tooth)	$8	100%	100%
	X-rays	$0	100%	100%
Basic Care	Fillings‡	$20-30	80%	80%
	Periodontal Maintenance	$28	80%	80%
	Frequency:	2 times in 12 months^ (Standard)	Once Every 3 Months (Enhanced)	
	Repair & Maintenance of Crowns, Bridges & Dentures	$16-230	80%	80%
	Simple Extractions	$23	80%	80%
Major Care	Anesthesia*	Restrictions Apply	50%	50%
	Bridges and Dentures	$580-675	50%	50%
	Dental Implants	Not Covered	50%	50%
	Inlays, Onlays, Veneers**	$250-420	50%	50%
	Perio Surgery	$105-210	50%	50%
	Root Canal	$126-192	50%	50%
	Scaling & Root Planing (per quadrant)	$25-42	50%	50%
	Single Crowns	$450	50%	50%
	Surgical Extractions	$46-116	50%	50%
Orthodontia	Orthodontia	$2,500-2,800	50%	50%
	Limits:	Adults & Child(ren)	Child(ren)	
Cosmetic Care	Bleaching	$165	Not Covered	Not Covered

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 filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age of 19; If full-time status is required by your plan 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. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡Fillings – restrictions may apply to composite fillings. (^Additional cleanings are available for an additional co-pay).

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.

Please Note: For your pre-paid plan, coinsurances relate to a fixed copayment amount, please refer to your plan schedule.

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 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 # GP-1-DG2000 et al.
- Important information about First Commonwealth Inc.'s and their subsidiaries' dental plans (Illinois, Missouri, Michigan and Indiana): 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 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 First Commonwealth. 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 First Commonwealth plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under First Commonwealth plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The First Commonwealth plan documents are the final arbiter of coverage. INS GMC 11/97; (IL) FCW-GMC-IL-08; (IN) FCW-GMC-IN-08; (MO) FCW-GMC-MO-08; (MI) FCW-GMC-MI-08
- **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.
Claims Payment Basis	**PPO** The usual cost for a specific dental service in your area. Amounts over the specified Usual Customary & Reasonable 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.
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.
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.
Pre-determination Review	Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable. This includes orthodontic treatment if your plan includes it. Pre-determination applies to PPO and Indemnity plans only.
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.
Preventive care	Most routine dental services. Most plans consider checkups and cleanings to be preventive care.