

Synch-Solutions



Benefits Plan

Here is your new coverage. **Make sure you return the completed form, if applicable, to your plan administrator.**

If you miss the deadline, the coverage may be delayed or you may not be eligible for enrollment this year.



HIGHLIGHTS:

- Comprehensive dental care for all your needs
- High-quality vision care coverage

Questions? Concerns?

Helpline (888) 600-1600
Call weekdays, 8:00AM to 8:30PM, EST

Learn more about Guardian at
www.guardianlife.com.



COVER YOURSELF WITH GUARDIAN

Guardian is a leading provider of employee benefits and individual insurance coverage.

Founded in 1860, The Guardian Life Insurance Company of America is one of the largest mutual life insurance companies in the United States. As a mutual company, Guardian is focused 100% on the needs of our customers – employers who choose Guardian and their employees covered by our plans. Today, more than six million employees and their families rely on Guardian as their employee benefits provider.

We have built our success on the time-tested values of quality, innovation and high-quality service. In July 2008 Standard & Poor's upgraded Guardian's credit rating to AA+ (Very Strong). We've been around for 150 years insuring the people and businesses we protect and we'll continue to provide benefits and services our customers have come to expect from us.

For more information on how we can protect you and your family, please visit www.GuardianLife.com

- Review your benefits.
- Complete your enrollment form, if applicable.
- Sign and return form to your plan administrator.

Welcome

Dear Synch-Solutions Employee,

We're pleased to tell you that Guardian will be our coverage provider this year. We have chosen Guardian because of its competitive rates, excellent service reputation, and extensive plan designs.

We have worked hard to negotiate group rates that will be affordable for all employees. All coverage is paid through payroll deduction.

Synch-Solutions

UNDERSTAND YOUR COVERAGE:

Plan Details This booklet explains your basic plan options. Your detailed certificate of benefits will be provided to you after you enroll.

Go online Learn more about your plans at www.guardianlife.com.

Call the Helpline Questions answered at (888) 600-1600.

Ask your plan administrator Change your plan by contacting your plan administrator.

Why Dental Insurance?

Good oral hygiene is important, not only for looks, but for general health as well. A routine dental examination can detect symptoms of more than 125 diseases, including heart disease, diabetes, anemia, stomach ulcers, osteoporosis and kidney disease. Regular check ups and cleanings can save you the pain and expense of future problems. Dental insurance will keep these visits affordable and is a cost-effective way to minimize health care costs for you and your family. The American Dental Hygienists' Association estimates that for every \$1 spent on prevention or oral health care, as much as \$8 to \$50 is saved on future emergency and restorative procedures. Using your dental insurance for regular dental check ups can improve your health by helping you:

- 1) Prevent Oral Cancer:** According to The Oral Cancer Foundation, someone dies from oral cancer every hour of every day in the United States alone. When you have your dental cleaning, your dentist is also screening you for oral cancer, which is highly curable if diagnosed early.
- 2) Prevent Gum Disease:** Gum disease is an infection in the gum tissues and bone that keep your teeth in place and is one of the leading causes of adult tooth loss. If diagnosed early, it can be treated and reversed. If treatment is not received, a more serious and advanced stage of gum disease may follow. Regular dental cleanings and check ups, flossing daily and brushing twice a day are key factors in preventing gum disease.
- 3) Help Maintain Good Physical Health:** Recent studies have linked heart attacks and strokes to gum disease, resulting from poor oral hygiene. A dental cleaning every six months helps to keep your teeth and gums healthy and could possibly reduce your risk of heart disease and strokes, as well as many other serious conditions.
- 4) Keep Your Teeth:** Since gum disease is one of the leading causes of tooth loss in adults, regular dental check ups and cleanings, brushing and flossing are vital to keeping as many teeth as you can. Keeping your teeth means better chewing function and ultimately, better health.
- 5) Prevent the Need for Advanced Treatment:** Your dentist and hygienist will be able to detect any early signs of problems with your teeth or gums that can be easily treatable. If these problems go untreated, root canals, gum surgery and removal of teeth could become the only treatment options available.
- 6) Have a Bright and White Smile:** Your dental hygienist can remove most tobacco, coffee and tea stains. During your cleaning, your hygienist will also polish your teeth to a beautiful shine.
- 7) Protect your children's health:** Tooth decay is the most common chronic childhood disease, five times more common than asthma and results in a loss of 51 million school hours each year. Regular check ups can help prevent tooth decay in your children.

Sources: www.about.com, *American Academy of Pediatrics*

Dental Plans

COMPARE YOUR 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	
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	100%	100%
Basic Care (e.g. fillings)	covered procedure. See	80%	80%
Major Care (e.g. crowns, dentures)	"Plan Details", over, for	50%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	\$1500	\$1500
Lifetime Orthodontia Maximum	Not Applicable		\$1500
Office visit copay	\$5		None
Monthly switch	Yes	Yes	
Network	First Commonwealth	DentalGuard Preferred	

YOUR GUARDIAN PLAN OFFERS:

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

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 October 01, 2010

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: DHMO 'U'	Option 2: PPO	
		You Pay	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	100%	100%
	Limits:	No Age Limits	Under Age 14	
	Oral Exams	\$0	100%	100%
	Sealants (per tooth)	\$0	100%	100%
	X-rays	\$0	100%	100%
Basic Care	Anesthesia	Restrictions Apply	80%	80%
	Fillings (one surface)	\$0	80%	80%
	Perio Surgery	\$200-380	80%	80%
	Periodontal Maintenance	\$0	80%	80%
	Frequency:	2 times in 12 months^	Once Every 3 Months	
		(Standard)	(Enhanced)	
	Root Canal	\$120-270	80%	80%
	Scaling & Root Planing (per quadrant)	\$0	80%	80%
	Simple Extractions	\$0	80%	80%
	Surgical Extractions	\$30-200	80%	80%
Major Care	Bridges and Dentures	\$381-575	50%	50%
	Dental Implants	Not Covered	50%	50%
	Inlays, Onlays, Veneers**	\$250-370	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	\$0-160	50%	50%
	Single Crowns	\$395	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 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.

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 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

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.

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.

Why Vision Insurance?

Eye care is health care. The health of your eyes is an indicator of your overall health, so it's important to have regular eye exams to detect diseases like glaucoma, diabetes, and blindness. Eye exams are also important for children, since good vision is closely linked to doing well in school. So, make sure you and your family visit your vision provider regularly. Vision insurance is a wellness benefit that can keep these important visits affordable by helping to defray costs of eye exams, eyewear, and other vision services.

There are many reasons why seeing an eyecare provider can help improve your health and way of life:

- 1) Early detection:** With regular eye exams, your eyecare professional can detect problems early and prescribe proper treatments to delay or prevent vision loss.
- 2) Fight disease:** Regular eye exams routinely detect early onset of glaucoma and diabetes, among other medical conditions. Left untreated, these diseases can have a devastating effect. Early intervention can result in reducing health concerns and financial impact.
- 3) Protect children's health and development:** Eye exams can play an important role in your child's growth because vision is closely linked to the learning process. Children who have trouble seeing or interpreting what they see will often have trouble with their schoolwork.
- 4) Keep your sight:** Blindness or low vision affects 3.3 million Americans age 40 and over. Researchers predict that figure will reach 5.5 million by 2020.

Source: Study conducted by the Eye Disease Prevalence Research Group and sponsored by the National Eye Institute, 2006

Vision Plans

UNDERSTAND YOUR PLAN

Visit any doctor with your **Full Feature** plan, but save by visiting any of the 34,000 locations in the nation's largest vision network.

UNDERSTAND YOUR PLAN	Vision
Copay	
Exams Copay	\$ 10
Materials Copay (waived for elective contact lenses)	\$ 25
Service Frequencies	
Exams	Every calendar year
Lenses (<i>for glasses or contact lenses</i>)**	Every calendar year
Frames	Every two calendar years
Network discounts (cosmetic extras, glasses and contact lens professional service)	Limitless within 12 months of exam.
Network	VSP

**Benefit includes coverage for glasses or contact lenses, not both.

YOUR GUARDIAN PLAN OFFERS:

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

Reduced prices An average 15% to 30% discount off an extensive list of "cosmetic extras", including special lenses and scratch-resistant coatings.

No claims submission for in-network services and supplies.

Did you know?

"Two-thirds of employees would rather trade a vacation day for eyecare benefits." – Bests Review, 2006

PLAN DETAILS

VISION

You pay (after copay if applicable):

	<i>In-network</i>	<i>Out-of-network</i>
Eye Exams	\$0	Amount over \$39
Single Vision Lenses	\$0	Amount over \$23
Lined Bifocal Lenses	\$0	Amount over \$37
Lined Trifocal Lenses	\$0	Amount over \$49
Lenticular Lenses	\$0	Amount over \$64
Frames	80% of amount over \$130	Amount over \$46
Contact Lenses (<i>Elective</i>)	Amount over \$130	Amount over \$100
Contact Lenses (<i>Medically Necessary</i>)	\$0	Amount over \$210
Contact Lenses (<i>Evaluation and fitting</i>)	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses (<i>Additional pair of frames and lenses</i>)	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

*** For the discount to apply your purchase must be made within 12 months of the eye exam.*

UNDERSTANDING YOUR BENEFITS—VISION

Bifocal Lenses	Lens with two focal lengths, one for distance and one for near. Usually the distance correction is on top and the correction for near is on the bottom.
Calendar Year	A type of Plan Year in which eligibility for services starts at the beginning of the calendar year, regardless of the date of service the previous year(s).
Contact Lens	A thin, bowl shaped lens worn on the surface of the eye to correct refractive error.
Contact Lenses (Elective)	Contact Lenses not required for the visual welfare of the patient. This is an optical choice over eyeglasses.
Contact Lenses (Evaluation & fitting)	Provided in addition to the routine eye exam for ensuring proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.
Contact Lenses (Medically necessary)	Medically necessary contacts are prescribed by a doctor as required for certain medical conditions that prevent you from wearing eyeglasses. Medically necessary contacts must be pre-approved.
Cosmetic Extras	A lens style, coating, or feature that enhances the appearance or functionality of a lens but is not required to meet the patient's visual needs. Also referred to as Cosmetic Options or Lens Coatings.
Eye Exams	Exam by an eye care practitioner, includes refractive and dilatation testing. Does not include evaluation for contact lenses.
Multifocal Lens	Eyeglass lens incorporating two or more different powers, usually three (trifocal).
In-network charges	Negotiated discounted fees charged by network providers.
Out-of-network charges	Fees charged by providers who are not part of the network. These fees are often higher than in-network charges.
Network Discounts	Discounts on non-covered services and materials that offer added value and savings to members.
PPO (Preferred Provider Organization)	Network of vision providers who have agreed to accept discounted fees from our members as payment in full.
Service frequency	Indicates when you will be eligible again for an exam or materials. These are based on the last date you received an exam or materials.
Single Vision Lens	Lens with one power, as opposed to bifocals, trifocals, quadrifocals or multifocals.

EXCLUSIONS AND LIMITATIONS:

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. 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-VSN-96-VIS et al.

Laser Correction Surgery:

- Up to 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to \$1,800 per eye for LASIK and \$1,500 per eye for PRK.
- Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.



Managed Dental Care of California
A Wholly Owned Subsidiary of Guardian

“BRIDGE DOCUMENT”

HOW YOUR MONTHLY SWITCH PLAN WORKS

Interaction between your Managed Dental Care Managed DentalGuard (MDG) Dental Plan
and
Guardian’s DentalGuard Preferred Dental Care Expense Coverage

HOW OUR CHOICEGUARD PLAN WORKS

There are two dental plans from which to choose:

- Managed Dental Care's Managed DentalGuard (MDG) Dental Plan; and
- Guardian's DentalGuard Preferred Dental Care Expense Coverage

CHOICE OF DENTISTS

Under the MDG Dental Plan, participating general dentists and participating specialist dentists provide the services. Each member must select a primary care dentist (PCD) or one will be assigned. There is no deductible and no annual maximum when participating dentists provide the services. There are Copayments that you and your covered dependents must pay for certain dental services.

Under the DentalGuard Preferred Dental Care Expense Coverage, a covered person may receive dental treatment from any dental provider he or she chooses. However, the plan usually pays a higher level of benefits for treatment furnished by a preferred provider. Conversely, it usually pays less for treatment furnished by a non-preferred provider. And, a deductible and payment limit may apply.

CHOICE OF PLANS

You may choose either plan for any given month. You can become covered for the MDG Dental Plan or the DentalGuard Preferred Dental Care Expense Coverage, but you cannot be covered under both plans at the same time or during the same month. Your plan selection will apply to all of your covered family members. To get more information about either plan, or to change from one plan to the other, you may call the Member Services toll-free number on your ID card, or submit a written request to the Managed Dental Care or Guardian address listed on your ID card.

ELIGIBILITY

The change in coverage to the other plan will be effective as follows:

- If the request is received on or before the 20th day of the month, the change will be effective on the first day of the following month.
- If the request is received after the 20th day of the month, the change will be effective on the first day of the month following the next month.

Once the change is effective, all the terms and conditions of the plan under which the person is covered will apply in lieu of the terms and conditions of the plan under which the person was covered immediately before the change in coverage. If you choose to switch from the DentalGuard Preferred Dental Care Expense Coverage to the MDG Dental Plan after having been previously covered under the MDG Dental Plan, each member will automatically be assigned his or her previous PCD. If the previous PCD is no longer available, a new PCD will be assigned, or if the member would like to select a new PCD, a request to select a new PCD must be made by the member to Managed Dental Care. Covered services or supplies obtained while a member is covered under the MDG plan will count toward the frequency limitations of the Guardian DentalGuard Preferred Dental Care Plan. And, treatment started under one plan will be deemed to continue under the terms and conditions of that plan until the treatment is completed, whether or not the member switches to the other plan during the course of such treatment. For further details, call the Member Services toll-free number on your ID card.

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004-2616

Managed Dental Care of California
6200 Canoga Avenue
Woodland Hills, CA 91367

CDT Codes ++	Covered Dental Services	Patient Charges
D0999	Office visit during regular hours, general dentist only *	\$5
	Evaluations	
D0120	Periodic oral examination – established patient	0
D0140	Limited oral evaluation – problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation – new or established patient	0
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)	0
D0180	Comprehensive periodontal evaluation – new or established patient	0
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Intraoral – complete series (including bitewings)	0
D0220	Intraoral – periapical first film	0
D0230	Intraoral – periapical each additional film	0
D0240	Intraoral – occlusal film	0
D0270	Bitewing – single film	0
D0272	Bitewings – two films	0
D0273	Bitewings – three films	0
D0274	Bitewings – four films	0
D0277	Vertical bitewings – 7 to 8 films	0
D0330	Panoramic film	0
	Tests and Examinations	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	Dental Prophylaxis	
D1110	Prophylaxis – adult, for the first two services in any 12-month period + #	0
D1120	Prophylaxis – child, for the first two services in any 12-month period + #	0
D1999	Prophylaxis – adult or child, for each additional service in same 12-month period + #	60
	Topical Fluoride Treatment (Office Procedure)	
D1203	Topical application of fluoride (prophylaxis not included) – child, for the first two services in any 12-month period + =	0
D1204	Topical application of fluoride (prophylaxis not included) – adult, for the first two services in any 12-month period + =	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12-month period + =	0
D2999	Topical fluoride (adult or child), each additional service in the same 12-month period + =	20
	Other Preventive Services	
D1310	Nutritional counseling for control of dental disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant – per tooth (molars) ^	0
D9999	Sealant – per tooth (non-molars) ^	35
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer – fixed - unilateral	0
D1515	Space maintainer – fixed - bilateral	0
D1525	Space maintainer – removable - bilateral	0
D1550	Re-cementation of space maintainer	0
D1555	Removal of fixed space maintainer	0
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam – one surface, primary or permanent	0
D2150	Amalgam – two surfaces, primary or permanent	0
D2160	Amalgam – three surfaces, primary or permanent	0
D2161	Amalgam – four or more surfaces, primary or permanent	0
	Resin-Based Composite Restorations - Direct	
D2330	Resin-based composite – one surface, anterior	0
D2331	Resin-based composite – two surfaces, anterior	0
D2332	Resin-based composite – three surfaces, anterior	0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	0
D2390	Resin-based composite crown, anterior	75
D2391	Resin-based composite – one surface, posterior	0
D2392	Resin-based composite – two surfaces, posterior	0
D2393	Resin-based composite – three surfaces, posterior	0
D2394	Resin-based composite – four or more surfaces, posterior	0
	Inlay/Onlay Restorations **	
D2510	Inlay – metallic – one surface **	265
D2520	Inlay – metallic – two surfaces **	320
D2530	Inlay – metallic – three or more surfaces **	350
D2542	Onlay – metallic – two surfaces **	350
D2543	Onlay – metallic – three surfaces **	360
D2544	Onlay – metallic – four or more surfaces **	370
D2610	Inlay – porcelain/ceramic – one surface	265
D2620	Inlay – porcelain/ceramic – two surfaces	320
D2630	Inlay – porcelain/ceramic – three or more surfaces	350
D2642	Onlay – porcelain/ceramic – two surfaces	350
D2643	Onlay – porcelain/ceramic – three surfaces	360
D2644	Onlay – porcelain/ceramic – four or more surfaces	370

CDT Codes ++	Covered Dental Services	Patient Charges
	Crowns – Single Restorations Only ^^	
D2740	Crown – porcelain/ceramic substrate	\$395
D2750	Crown – porcelain fused to high noble metal **	375
D2751	Crown – porcelain fused to predominantly base metal	375
D2752	Crown – porcelain fused to noble metal	375
D2780	Crown – ¾ cast high noble metal **	365
D2781	Crown – ¾ cast predominantly base metal	365
D2782	Crown – ¾ cast noble metal	365
D2783	Crown – ¾ porcelain/ceramic	365
D2790	Crown – full cast high noble metal **	375
D2791	Crown – full cast predominantly base metal	375
D2792	Crown – full cast noble metal	375
D2794	Crown – titanium	375
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	0
D2915	Recement cast or prefabricated post and core	0
D2920	Recement crown	0
D2930	Prefabricated stainless steel crown – primary tooth	88
D2931	Prefabricated stainless steel crown – permanent tooth	88
D2932	Prefabricated resin crown	108
D2933	Prefabricated stainless steel crown with resin window	108
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	115
D2940	Sedative filling	0
D2950	Core buildup, including any pins	100
D2951	Pin retention – per tooth, in addition to restoration	18
D2952	Post and core in addition to crown, indirectly fabricated	155
D2953	Each additional indirectly fabricated post – same tooth	79
D2954	Prefabricated post and core in addition to crown	125
D2957	Each additional prefabricated post – same tooth	51
D2960	Labial veneer (resin laminate) – chairside	250
D2970	Temporary crown (fractured tooth)	86
D2971	Additional procedures to construct new crown under existing partial denture framework	125
	Pulp Capping	
D3110	Pulp cap – direct (excluding final restoration)	0
D3120	Pulp cap – indirect (excluding final restoration)	0
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	0
D3221	Pulpal debridement, primary and permanent teeth	0
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	0
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	0
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-up Care)	
D3310	Root canal, anterior (excluding final restoration)	120
D3320	Root canal, bicuspid (excluding final restoration)	145
D3330	Root canal, molar (excluding final restoration)	270
D3331	Treatment of root canal obstruction; non-surgical access	0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75
D3333	Internal root repair of perforation defects	116
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy – anterior	375
D3347	Retreatment of previous root canal therapy – bicuspid	425
D3348	Retreatment of previous root canal therapy – molar	525
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery – anterior	240
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	270
D3425	Apicoectomy/periradicular surgery – molar (first root)	320
D3426	Apicoectomy/periradicular surgery (each additional root)	116
D3430	Retrograde filling – per root	72
D3950	Canal preparation and fitting of preformed dowel or post	20
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	200
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	60
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	240
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	144
D4249	Clinical crown lengthening – hard tissue	280
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	380
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	230
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	350
D4271	Free soft tissue graft procedure (including donor site surgery)	363
D4273	Subepithelial connective tissue graft procedures, per tooth	399

CDT Codes ++	Covered Dental Services	Patient Charges
Non-Surgical Periodontal Service		
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$0
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0
Other Periodontal Services		
D4910	Periodontal maintenance, for the first two services in any 12-month period + #	0
D4920	Unscheduled dressing change (by someone other than treating dentist)	0
D4999	Periodontal maintenance, each additional service in same 12-month period + #	60
Complete Dentures (Including Routine Post-Delivery Care)		
D5110	Complete denture – maxillary	452
D5120	Complete denture – mandibular	452
D5130	Immediate denture – maxillary	492
D5140	Immediate denture – mandibular	492
Partial Dentures (Including Routine Post-Delivery Care)		
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	381
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	443
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	575
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	575
Adjustments to Dentures		
D5410	Adjust complete denture – maxillary	0
D5411	Adjust complete denture – mandibular	0
D5421	Adjust partial denture – maxillary	0
D5422	Adjust partial denture – mandibular	0
Repairs To Complete Dentures		
D5510	Repair broken complete denture base	40
D5520	Replace missing or broken teeth – complete denture (each tooth)	36
Repairs To Partial Dentures		
D5610	Repair resin denture base	44
D5620	Repair cast framework	80
D5630	Repair or replace broken clasp	56
D5640	Replace broken teeth – per tooth	36
D5650	Add tooth to existing partial denture	52
D5660	Add clasp to existing partial denture	64
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	196
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	196
Denture Rebase Procedures		
D5710	Rebase complete maxillary denture	160
D5711	Rebase complete mandibular denture	160
D5720	Rebase maxillary partial denture	160
D5721	Rebase mandibular partial denture	160
Denture Reline Procedures		
D5730	Reline complete maxillary denture (chairside)	88
D5731	Reline complete mandibular denture (chairside)	88
D5740	Reline maxillary partial denture (chairside)	88
D5741	Reline mandibular partial denture (chairside)	88
D5750	Reline complete maxillary denture (laboratory)	120
D5751	Reline complete mandibular denture (laboratory)	120
D5760	Reline maxillary partial denture (laboratory)	120
D5761	Reline mandibular partial denture (laboratory)	120
Interim Prosthesis		
D5820	Interim partial denture (maxillary)	175
D5821	Interim partial denture (mandibular)	175
Other Removable Prosthetic Services		
D5850	Tissue conditioning, maxillary	36
D5851	Tissue conditioning, mandibular	36
Fixed Partial Denture Pontics ^^		
D6210	Pontic – cast high noble metal *	350
D6211	Pontic – cast predominantly base metal	350
D6212	Pontic – cast noble metal	350
D6214	Pontic – titanium	350
D6240	Pontic – porcelain fused to high noble metal *	350
D6241	Pontic – porcelain fused to predominantly base metal	350
D6242	Pontic – porcelain fused to noble metal	350
D6245	Pontic – porcelain/ceramic	360
Fixed Partial Denture Retainers -- Inlays/Onlays ^^		
D6600	Inlay – porcelain/ceramic – two surfaces	320
D6601	Inlay – porcelain/ceramic – three or more surfaces	350
D6602	Inlay – cast high noble metal, two surfaces **	320
D6603	Inlay – cast high noble metal, three or more surfaces **	350
D6604	Inlay – cast predominantly base metal, two surfaces	320

CDT Codes ++	Covered Dental Services	Patient Charges
Fixed Partial Denture Retainers – Inlays/Onlays ^^ (continued)		
D6605	Inlay – cast predominantly base metal, three or more surfaces	\$350
D6606	Inlay – cast noble metal, two surfaces	320
D6607	Inlay – cast noble metal, three or more surfaces	350
D6608	Onlay – porcelain/ceramic, two surfaces	350
D6609	Onlay – porcelain/ceramic, three or more surfaces	360
D6610	Onlay – cast high noble metal, two surfaces **	350
D6611	Onlay – cast high noble metal, three or more surfaces **	360
D6612	Onlay – cast predominantly base metal, two surfaces	350
D6613	Onlay – cast predominantly base metal, three or more surfaces	360
D6614	Onlay – cast noble metal, two surfaces	350
D6615	Onlay – cast noble metal, three or more surfaces	360
D6624	Inlay – titanium	350
D6634	Onlay – titanium	350
Fixed Partial Denture Retainers – Crowns ^^		
D6740	Crown – porcelain/ceramic	395
D6750	Crown – porcelain fused to high noble metal **	375
D6751	Crown – porcelain fused to predominantly base metal	375
D6752	Crown – porcelain fused to noble metal	375
D6780	Crown – ¾ cast high noble metal **	365
D6781	Crown – ¾ cast predominantly base metal	365
D6782	Crown – ¾ cast noble metal	365
D6783	Crown – ¾ porcelain/ceramic	365
D6790	Crown – full cast high noble metal **	375
D6791	Crown – full cast predominantly base metal	375
D6792	Crown – full cast noble metal	375
D6794	Crown – titanium	375
Other Fixed Partial Denture Services		
D6930	Recement fixed partial denture	36
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	155
D6972	Prefabricated post and core in addition to fixed partial denture retainer	125
D6973	Core build up for retainer, including any pins	100
D6976	Each additional cast post – same tooth	79
D6977	Each additional prefabricated post – same tooth	51
D6999	Multiple crown and bridge unit treatment plan – per unit, six or more units per treatment plan ^^	125
Extractions		
D7111	Extraction, coronal remnants – deciduous tooth	0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0
Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)		
D7210	Surgical removal of erupted tooth – requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	30
D7220	Removal of impacted tooth – soft tissue	114
D7230	Removal of impacted tooth – partially bony	140
D7240	Removal of impacted tooth – completely bony	160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	200
D7250	Surgical removal of residual tooth roots (cutting procedure)	35
D7261	Primary closure of a sinus perforation	250
Other Surgical Procedures		
D7280	Surgical access of an unerupted tooth	250
D7283	Placement of device to facilitate eruption of impacted tooth	50
D7285	Biopsy of oral tissue – hard (bone, tooth)	60
D7286	Biopsy of oral tissue – soft	50
D7288	Brush biopsy – transepithelial sample collection	65
Alveoloplasty – Surgical Preparation Of Ridge For Dentures		
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	125
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	65
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	150
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	105
Surgical Excision Of Intra-Osseous Lesions		
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	289
Excision Of Bone Tissue		
D7471	Removal of lateral exostosis (maxilla or mandible)	204
D7472	Removal of torus palatinus	283
D7473	Removal of torus mandibularis	283
Surgical Incision		
D7510	Incision and drainage of abscess – intraoral soft tissue	25
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	30
Other Repair Procedures		
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	133
D7963	Frenuloplasty	163

CDT Codes ++	Covered Dental Services	Patient Charges
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$0
D9120	Fixed partial denture sectioning	15
D9215	Local anesthesia	0
D9220	Deep sedation/general anesthesia – first 30 minutes +++	195
D9221	Deep sedation/general anesthesia – each additional 15 minutes +++	75
D9241	Intravenous conscious sedation/analgesia – first 30 minutes ++	195
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes +++	75
	Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	0
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	0
D9440	Office visit – after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
	Miscellaneous Services	
D9951	Occlusal adjustment – limited	10
D9971	Odontoplasty – one to two teeth	10
D9972	External bleaching – per arch	165
	Broken appointment	25

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- + The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12-month period. For each additional service in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.
- ++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan booklet and the Manual (including the Quality Management retrospective review). Other codes may be used to describe Covered Services.
- * The Member will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is an "M". The Plan will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is a "G". The ID Card and Eligibility Report will indicate if the Office Visit Fee is \$5 or \$10.
- # Routine prophylaxis or periodontal maintenance procedure - a total of four services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a participating periodontal Specialist if done within three to six months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a participating periodontal Specialist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- = Fluoride Treatment - a total of four services in any 12-month period.
- ^ Sealants are limited to permanent teeth up to the 16th birthday.
- ** If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.
- ^^ The Patient Charge for these services is per unit.
- +++ Procedure codes D9220, D9221, D9241 and D9242 are limited to a participating oral surgery Specialist. Additionally, these services are only covered in conjunction with other covered surgical services.

Underwritten by: (IL) - First Commonwealth Insurance Company, (MO) - First Commonwealth of Missouri, (IN) - First Commonwealth Limited Health Services Corporation, (MI) - First Commonwealth Inc., (CA) - Managed Dental Care, (TX) - Managed DentalGuard, Inc. (DHMO), (NJ) - Managed DentalGuard, Inc., (FL, NY) - The Guardian Life Insurance Company of America. All First Commonwealth, Managed DentalGuard, Inc., and Managed Dental Care entities referenced are wholly-owned subsidiaries of The Guardian Life Insurance Company of America. Limitations and exclusions apply. Plan documents are the final arbiter of coverage.

MANAGED DENTALGUARD ORTHODONTIC BENEFITS

Managed DentalGuard Orthodontic Plan Schedule – Option V

CDT Codes	Covered Services and Patient Charges	Patient Charges	Orthodontics In Progress
	Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition **		
D8080	Comprehensive orthodontic treatment of the adolescent dentition **	Child: \$2500	***
D8090	Comprehensive orthodontic treatment of the adult dentition **	Adult: 2800	***
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	250	***
D8670	Periodic orthodontic treatment visit	0	***
D8680	Orthodontic retention	400	***
	Broken appointment	25	***

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** Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above and employee or spouse. A Member's age is determined on the date of banding.

*** Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Plan Schedule and were started but not completed prior to the Member's eligibility to receive benefits under this plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation retention services would also be at 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this plan, the Patient Charge for orthodontic retention is equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan Booklet and the Manual.

The Plan Covers:

- Orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one (1) course of treatment per Member. We must preauthorize treatment, and it must be performed by a Participating Orthodontic Specialist Dentist.
- Up to twenty-four (24) months of comprehensive orthodontic treatment.
- Treatment plan and records, including initial records and any interim and final records.
- Comprehensive orthodontic treatment, including the fixed banding appliances and related visits only.
- Retention services following a course of comprehensive orthodontic treatment that was covered under this Plan.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialist Dentist's usual fee.

This Plan Does Not Cover:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under MDG.
- Orthodontic treatment performed by any dentist other than a Participating Orthodontic Specialist Dentist.
- Limited orthodontic treatment and interceptive (Phase I) treatment.
- Treatment beyond twenty-four (24) months. (The Member will be responsible for an additional charge for each additional month of treatment, based upon the Participating Orthodontic Specialist Dentist's contracted fee.)
- Except as described under treatment in progress – orthodontic treatment, orthodontic services are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan. If a Member's coverage terminates after the fixed banding appliances are inserted, the Participating Orthodontist Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment.
- Orthodontic services after a Member's coverage terminates.
- Any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets.
- Procedures, appliances or devices to (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.
- Extractions performed solely to facilitate orthodontic treatment.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- If a Member transfers to another Participating Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

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