

Dental Plans

Option 1: With your **Dental HMO** 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 **Dental 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: Dental HMO	Option 2: Dental PPO	
Network	First Commonwealth	DentalGuard Preferred	
Calendar year deductible		<i>In-Network</i>	<i>Out-Network</i>
Individual	No deductible	\$0	\$25
Family limit		3 per family	
Waived for		Not applicable	None
Charges covered for you (co-insurance)	<i>Network only</i>	<i>In-Network</i>	<i>Out-Network</i>
Preventive Care (e.g. cleanings)	You pay a copay for each	100%	100%
Basic Care (e.g. fillings)	covered procedure. See	90%	80%
Major Care (e.g. crowns, dentures)	"Plan Details", for	60%	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 (Non-Student/Student)	20/26		20/26

YOUR GUARDIAN PLAN OFFERS:

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

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: Dental HMO	Option 2: Dental PPO	
		Plan Pays (on average)	In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%
	Frequency:	Once every 6 months	Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%
	Limits:	No Age Limits	Under Age 19	
	Oral Exams	100%	100%	100%
	X-rays	100%	100%	100%
Basic Care	Anesthesia*	50%	90%	80%
	Fillings‡	85%	90%	80%
	Perio Surgery	85%	90%	80%
	Periodontal Maintenance	85%	90%	80%
	Frequency:	Once every 6 months (Standard)	Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	90%	80%
	Root Canal	85%	90%	80%
	Scaling & Root Planing (per quadrant)	85%	90%	80%
	Simple Extractions	85%	90%	80%
	Surgical Extractions	85%	90%	80%
	Major Care	Bridges and Dentures	80%	60%
Inlays, Onlays, Veneers**		50-80%	60%	50%
Single Crowns		80%	60%	50%
Orthodontia	Orthodontia	\$1,000 Savings	50%	50%
	Limits:	Adults & Child(ren)	Child(ren)	

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; 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.

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

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.