GUARDIAN ® DENTAL COVERAGE FOR INDIVIDUALS AND FAMILIES ON THE HEALTH INSURANCE EXCHANGE FOR ILLINOIS

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Guardian's DHMO Plan

The Guardian DentalGuard DHMO plans allow you to choose to receive care from any participating licensed dentist in our DHMO network, and pay a set co-pay for your office visit. Under this plan, you must choose a primary care dentist. All of your dental care will be provided by, or arranged by, your primary care dentist.

Under the Affordable Care Act (ACA), insurers must provide coverage for 10 essential health benefits (EHBs). This plan includes the pediatric essential health benefit, which is a comprehensive set of dental services for children under 19. These services are covered without annual or lifetime limits as long as you receive care-in-network. Also included is coverage for medically necessary orthodontics.

Managed DentalGuard Family Plan—For Plan Years Beginning in 2016		
	In-Network	Out-of-Network
You Pay (Average cost is illustrated below. Refer to detailed list on the following pages.)		
Diagnosis & Preventive Care **-Members age 19 and older** **-Members up to age 19** *Exams, cleaning, x-rays	$0 $2	Not Covered
Basic Services **-Members age 19 and older** **-Members up to age 19** *Fillings, simple tooth extractions	$70 $65	Not Covered
Major Services **-Members age 19 and older** **-Members up to age 19** *Crowns, inlays, onlays, and cast restorations	$346 $348	Not Covered
Standard Orthodontic Coverage (without verification of medical necessity) D8080 *Comprehensive Orthodontic Treatment of the Adolescent	$2,500	Not Covered
Standard Orthodontic Coverage (without verification of medical necessity) D8090 *Comprehensive Orthodontic Treatment of the Adult	$2,800	Not Covered
Office Visit	$15	Not Covered
Out of Pocket Maximum (Individual / Family) – Applies to child essential health benefits only)	$350 / $700	Not Covered
Annual Maximum	None	N/A

 Note: Procedures listed above under Preventive, Basic, Major and Orthodontics are for sample purposes only and do not encompass all covered services. For a list of co-payments for all covered services, please see the Covered Dental Services And Patient Charges on the following pages, and your policy contract for details. Limitations and exclusions apply. Plan documents are the final arbiter of coverage. FCW-GMC-FP-IL-15

Plan designs are not available in the following counties: Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, Dekalp, Dewitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquios, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Knox, La Salle, Lawrence, Lee, Livingston, Logan, Macon, Maroupin, Marion, Marshall, Mason, Massac, Mcdonough, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Schuyler, Scott, Shelby, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Williamson, Woodford

Covered Dental Services and Patient Charges – U10ILI02

The services covered by this Policy are named in this list. If a service, treatment or procedure is not on this list, it is not a covered service. All services must be provided by the assigned Primary Care Dentist. The Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of this Policy, including the Limitations and Conditions on Covered Dental Services and Exclusions.

There is a limit on the total amount of Patient Charges a Member who is under age 19 must pay each calendar year for pediatric essential health benefits as determined by Illinois. The limit is $350.00 for each such Member. Once this limit is reached the plan waives Patient Charges for such benefits for the rest of the calendar year for such Member. But if two or more such Members meet the limit of $700.00 in a calendar year, the plan waives the Patient Charges for such benefits for all other such Members for the rest of the calendar year.

The Patient Charges listed this section are only valid for covered services that are: (1) started and completed under this Policy, and (2) rendered by Participating Dentists in the State of Illinois.

Covered Services and Patient Charges		
CDT Codes++		**Plan Schedules - Patient Charges**
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - 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
D0210	Intraoral - complete series of radiographic images	0
D0220	Intraoral - periapical first radiographic image	0
D0230	Intraoral - periapical each additional radiographic image	0
D0240	Intraoral - occlusal radiographic image	0
D0270	Bitewing - single radiographic image	0
D0272	Bitewings - two radiographic images	0
D0273	Bitewings - three radiographic images	0
D0274	Bitewings - four radiographic images	0
D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	0
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
D0999	Office visit during regular hours, general dentist only	15
D1000-D1999	**II. PREVENTIVE**	
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
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 application of fluoride varnish, for the first two services in any 12-month period+=	12
D1208	Topical application of fluoride+=	0
D2999	Topical fluoride (adult or child), each additional service in the same 12-month period+=	20
D1310	Nutritional counseling for control of dental disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant - per tooth (molars)##	14
D9999	Sealant - per tooth (non-molars)##	35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth##	14
D1510	Space maintainer - fixed – unilateral	75
D1515	Space maintainer - fixed – bilateral	110
D1525	Space maintainer - removable - bilateral	110
D1550	Re-cementation of space maintainer	13
D1555	Removal of fixed space maintainer	20

Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D2000-D2999	III. RESTORATIVE ###	
D2140	Amalgam - one surface, primary or permanent	$28
D2150	Amalgam - two surfaces, primary or permanent	39
D2160	Amalgam - three surfaces, primary or permanent	46
D2161	Amalgam - four or more surfaces, primary or permanent	57
D2330	Resin-based composite - one surface, anterior	36
D2331	Resin-based composite - two surfaces, anterior	44
D2332	Resin-based composite - three surfaces, anterior	58
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	66
D2390	Resin-based composite crown, anterior	95
D2391	Resin-based composite - one surface, posterior	56
D2392	Resin-based composite - two surfaces, posterior	75
D2393	Resin-based composite - three surfaces, posterior	90
D2394	Resin-based composite - four or more surfaces, posterior	95
D2510	Inlay - metallic - one surface**	326
D2520	Inlay - metallic - two surfaces**	368
D2530	Inlay - metallic - three or more surfaces**	383
D2542	Onlay - metallic - two surfaces**	383
D2543	Onlay - metallic - three surfaces**	400
D2544	Onlay - metallic - four or surfaces**	420
D2610	Inlay - porcelain/ceramic - one surface	326
D2620	Inlay - porcelain/ceramic - two surfaces	368
D2630	Inlay - porcelain/ceramic - three or more surfaces	383
D2642	Onlay - porcelain/ceramic - two surfaces	383
D2643	Onlay - porcelain/ceramic - three surfaces	400
D2644	Onlay - porcelain/ceramic - four or more surfaces	420
D2740	Crown - porcelain/ceramic substrate	450
D2750	Crown - porcelain fused to high noble metal**	430
D2751	Crown - porcelain fused to predominately base metal	430
D2752	Crown - porcelain fused to noble metal	430
D2780	Crown - 3/4 cast high noble metal**	420
D2781	Crown - 3/4 cast predominately base metal	420
D2782	Crown - 3/4 cast noble metal	420
D2783	Crown - 3/4 porcelain/ceramic	420
D2790	Crown - full cast high noble metal**	430
D2791	Crown - full cast predominately base metal	430
D2792	Crown - full cast noble metal	430
D2794	Crown - titanium	430
D2910	Recement inlay, onlay, or partial coverage restoration	18
D2915	Recement cast or prefabricated post and core	18
D2920	Recement crown	18
D2929	Prefabricated porcelain/ceramic crown - primary tooth	135
D2930	Prefabricated stainless steel crown - primary tooth	110
D2931	Prefabricated stainless steel crown - permanent tooth	125
D2932	Prefabricated resin crown	135
D2933	Prefabricated stainless steel crown with resin window	135
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	145
D2940	Sedative filling	30
D2950	Core buildup, including any pins	113
D2951	Pin retention - per tooth, in addition to restoration	24
D2952	Post and core, in addition to crown, indirectly fabricated	160
D2953	Each additional indirectly fabricated post - same tooth	50
D2954	Prefabricated post and core in addition to crown	130
D2957	Each additional prefabricated post - same tooth	29
D2960	Labial veneer (resin laminate) - chairside	250
D2970	Temporary crown (fractured tooth)	100
D2971	Additional procedures to construct new crown under existing partial denture framework	125
D2990	Resin infiltration of incipient smooth surface lesions	5

Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D3000-D3999	**IV. ENDODONTICS**	
D3110	Pulp cap - direct (excluding final restoration)	$15
D3120	Pulp cap - indirect (excluding final restoration)	15
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	50
D3221	Pulpal debridement, primary and permanent teeth	50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	88
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	90
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	260
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	300
D3330	Endodontic therapy, molar (excluding final restoration)	400
D3331	Treatment of root canal obstruction, non-surgical access	0
D3332	Incomplete endodontic therapy, inoperable, unrestorable or fractured tooth	150
D3333	Internal root repair of perforation defects	120
D3346	Retreatment of previous root canal therapy - anterior	315
D3347	Retreatment of previous root canal therapy - bicuspid	370
D3348	Retreatment of previous root canal therapy - molar	445
D3410	Apicoectomy/periradicular surgery - anterior	265
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	300
D3425	Apicoectomy/periradicular surgery - molar (first root)	350
D3426	Apicoectomy/periradicular surgery - (each additional root)	110
D3430	Retrograde filling - per root	90
D3950	Canal preparation and fitting of preformed dowel or post	20
D4000-D4999	**V. PERIODONTICS**	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	188
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	85
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	60
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	275
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	165
D4249	Clinical crown lengthening - hard tissue	285
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	410
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	350
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	295
D4271	Free soft tissue graft procedure (including donor site surgery)	298
D4273	Subepithelial connective tissue graft procedures, per tooth	328
D4277	Free soft tissue graft procedure (including donor site surgery) first tooth or edentulous tooth position in a graft	298
D4278	Free soft tissue graft procedure (including donor site surgery) each additional contiguous tooth or edentulous tooth position in a graft	179
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	50
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	35
D4910	Periodontal maintenance, for the first two services in any 12-month period+#	32
D4920	Unscheduled dressing change (by someone other than treating dentist)	25
D4999	Periodontal maintenance, each additional service in same 12-month period+#	60
D5000-D5999	**VI. PROSTHODONTICS (removable)**	
D5110	Complete denture - maxillary	$580
D5120	Complete denture - mandibular	580
D5130	Immediate denture - maxillary	620
D5140	Immediate denture - mandibular	620
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	580
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	580
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	675
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	675

Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D5000-D5999	**VI. PROSTHODONTICS (removable) – cont.**	
D5410	Adjust complete denture - maxillary	$27
D5411	Adjust complete denture - mandibular	27
D5421	Adjust partial denture – maxillary	27
D5422	Adjust partial denture – mandibular	27
D5510	Repair broken complete denture base	69
D5520	Replace missing or broken teeth - complete denture (each tooth)	66
D5610	Repair resin denture base	80
D5620	Repair cast framework	80
D5630	Repair or replace broken clasp	96
D5640	Replace broken teeth - per tooth	62
D5650	Add tooth to existing partial denture	81
D5660	Add clasp to existing partial denture	102
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	223
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	223
D5710	Rebase complete maxillary denture	230
D5711	Rebase complete mandibular denture	230
D5720	Rebase maxillary partial denture	230
D5721	Rebase mandibular partial denture	230
D5730	Reline complete maxillary denture (chairside)	130
D5731	Reline complete mandibular denture (chairside)	130
D5740	Reline maxillary partial denture (chairside)	125
D5741	Reline mandibular partial denture (chairside)	125
D5750	Reline complete maxillary denture (laboratory)	186
D5751	Reline complete mandibular denture (laboratory)	186
D5760	Reline maxillary partial denture (laboratory)	186
D5761	Reline mandibular partial denture (laboratory)	186
D5820	Interim partial denture (maxillary)	190
D5821	Interim partial denture (mandibular)	190
D5850	Tissue conditioning, maxillary	60
D5851	Tissue conditioning, mandibular	60
D5900-D5999	**VII. MAXILLOFACIAL PROSTHETICS –MEDICAL NECESSITY**	
D5931	Obturator prosthesis, surgical #####	$2,415
D5932	Obturator prosthesis, definitive #####	1,687
D5933	Obturator prosthesis, modification #####	245
D5936	Obturator prosthesis, interim #####	4,023
D6000-D6199	**VIII. IMPLANT SERVICES - Not Covered**	
D6200-D6999	**IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge]) ###**	
D6210	Pontic - cast high noble metal**	$400
D6211	Pontic - cast predominately base metal	400
D6212	Pontic - cast noble metal	400
D6214	Pontic – titanium	400
D6240	Pontic - porcelain fused to high noble metal**	400
D6241	Pontic - porcelain fused to predominately base metal	400
D6242	Pontic - porcelain fused to noble metal	400
D6245	Pontic - porcelain/ceramic	410
D6600	Inlay - porcelain/ceramic - two surfaces	368
D6601	Inlay - porcelain/ceramic - three or more surfaces	383
D6602	Inlay - cast high noble metal, two surfaces**	368
D6603	Inlay - cast high noble metal, three or more surfaces**	383
D6604	Inlay - cast predominantly base metal, two surfaces	368
D6605	Inlay - cast predominantly base metal, three or more surfaces	383
D6606	Inlay - cast noble metal, two surfaces	368
D6607	Inlay - cast noble metal, three or more surfaces	383
D6608	Onlay - porcelain/ceramic - two surfaces	383
D6609	Onlay - porcelain/ceramic - three or more surfaces	400
D6610	Onlay - cast high noble metal, two surfaces**	383

Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D6200-D6999	**IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit of fixed partial denture [bridge]) ### - cont.**	
D6611	Onlay - cast high noble metal, three or more surfaces**	$400
D6612	Onlay - cast predominantly base metal, two surfaces	383
D6613	Onlay - cast predominantly base metal, three or more surfaces	400
D6614	Onlay - cast noble metal, two surfaces	383
D6615	Inlay - cast noble metal, three or more surfaces	400
D6624	Inlay – titanium	368
D6634	Onlay – titanium	383
D6740	Crown - porcelain/ceramic	450
D6750	Crown - porcelain fused to high noble metal**	430
D6751	Crown - porcelain fused to predominately base metal	430
D6752	Crown - porcelain fused to noble metal	430
D6780	Crown - 3/4 cast high noble metal**	430
D6781	Crown - 3/4 cast predominately base metal	430
D6782	Crown - 3/4 cast noble metal	430
D6783	Crown - 3/4 porcelain/ceramic	430
D6790	Crown - full cast high noble metal**	430
D6791	Crown - full cast predominately base metal	430
D6792	Crown - full cast noble metal	430
D6794	Crown - titanium	430
D6930	Recement fixed partial denture	26
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	160
D6972	Prefabricated post and core in addition to fixed partial denture retainer	130
D6973	Core build up for retainer, including any pins	113
D6976	Each additional cast post - same tooth	50
D6977	Each additional prefabricated post - same tooth	29
D6999	Multiple crown and bridge unit treatment plan - per unit, six or more units per treatment plan ###	125
D7000-D7999	**X. ORAL AND MAXILLOFACIAL SURGERY**	
D7111	Extraction, coronal remnants - deciduous tooth	$20
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	35
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	110
D7220	Removal of impacted tooth - soft tissue	145
D7230	Removal of impacted tooth - partially bony	180
D7240	Removal of impacted tooth - completely bony	215
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	240
D7250	Surgical removal of residual tooth roots (cutting procedure)	110
D7261	Primary closure of a sinus perforation	250
D7280	Surgical access of an unerupted tooth	250
D7283	Placement of device to facilitate eruption of impacted tooth	35
D7285	Biopsy of oral tissue - hard (bone, tooth)	125
D7286	Biopsy of oral tissue - soft	85
D7288	Brush biopsy - transepithelial sample collection	65
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	53
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	26
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	92
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	65
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	200
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	260
D7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	406
D7461	Removal of nonodontogenic cyst or tumor - lesion diameter greater than to 1.25cm	406
D7471	Removal of lateral exostosis (maxilla or mandible)	215
D7472	Removal of torus palatinus	215
D7473	Removal of torus mandibularis	215
D7510	Incision and drainage of abscess - intraoral soft tissue	44
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	48
D7610	Maxilla - open reduction (teeth immobilized, if present) #####	1,500
D7620	Maxilla - closed reduction (teeth immobilized, if present) #####	1,100

Covered Services and Patient Charges

CDT Codes++		Plan Schedules - Patient Charges
D7000-D7999	**X. ORAL AND MAXILLOFACIAL SURGERY – cont.**	
D7630	Mandible - open reduction (teeth immobilized, if present) #####	$5,000
D7640	Mandible - closed reduction (teeth immobilized, if present) #####	2,200
D7710	Maxilla - open reduction #####	495
D7720	Maxilla - closed reduction #####	3,513
D7730	Mandible - open reduction #####	1,129
D7740	Mandible - closed reduction #####	1,020
D7955	Repair of maxillofacial soft and/or hard tissue defect #####	1,500
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	100
D7963	Frenuloplasty	168
D9000-D9999	**XII. ADJUNCTIVE GENERAL SERVICES**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$25
D9120	Fixed partial denture sectioning	30
D9215	Local anesthesia	0
D9220	Deep sedation/general anesthesia - first 30 minutes+++	195
D9221	Deep sedation/general anesthesia - each additional 15 minutes+++	75
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis+++####	185
D9241	Intravenous conscious sedation/analgesia - first 30 minutes+++	195
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes+++	75
D9248	Non-intravenous conscious sedation+++####	125
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	34
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	10
D9440	Office visit - after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
D9610	Therapeutic drug injection, by report ####	79
D9951	Occlusal adjustment – limited	23
D9971	Odontoplasty - one to two teeth	23
D9972	Bleaching - per arch	165
D9975	Bleaching for home application, per arch; includes material and fabrication of custom trays	99
	Broken appointment	25

Current Dental Terminology (CDT) @ American Dental Association (ADA)

+ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206, D1208, 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.

++++ Routine exams/evaluations – covered once every six months in a dental office setting and once every 12 months in a school setting

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 19th 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 code limited to dependent children under age 19.

+++ Procedure codes D9220, D9221, D9230, D9241, D9242 and D9248 are limited to a participating oral surgery Specialist. Additionally, these services are only covered in conjunction with other surgical services.

Plan schedules is only valid for Covered Services rendered by Participating Dentists in the State of Illinois.
Underwritten by: First Commonwealth Insurance Company - (IL), First Commonwealth of Missouri - (MO), First Commonwealth Limited Health Services Corporation - (IN), First Commonwealth Limited Health Services Corporation of Michigan - (MI), Managed Dental Care - (CA), Managed DentalGuard, Inc. - (NJ, OH, TX), The Guardian Life Insurance Company of America - (CO, FL, NY and all PPO and Indemnity plans). All referenced companies are wholly owned subsidiaries of The Guardian Life Insurance Company of America, New York, NY.

Covered Services and Patient Charges		
CDT Codes++		**Plan Schedules - Patient Charges**
D8000-D8999	**XI. ORTHODONTICS**	
D8070	Comprehensive orthodontic treatment of the transitional dentition**	$2,500
D8080	Comprehensive orthodontic treatment of the adolescent dentition**	$2,500
D8090	Comprehensive orthodontic treatment of the adult dentition**	$2,800
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	$400
	Broken appointment	$25

Current Dental Terminology (CDT) @ American Dental Association (ADA)

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

++ Covered Services are subject to exclusions, limitations, and Plan provisions as described in Member's Plan Booklet and the Manual. Child orthodontics is limited to children meeting or exceeding a score of 42 from the Modified Salxmann Index or meeting criteria for medical necessity.

The Policy 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 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 Policy.
- 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 Policy 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 Policy Does Not Cover:

- Any Procedure listed as an exclusion, in excess of Policy limitations, or as not covered under First Commonwealth.
- Orthodontic treatment performed by any dentist other than a Participating Orthodontic Specialty Dentist.
- Limited orthodontic treatment and Interceptive (Phase 1) 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 Specialists 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 Policy. 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 Policy, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.