MetLife

SCHEDULE OF BENEFITS

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

Direct Referral Dental Plan* METCO3C

This SCHEDULE OF BENEFITS lists the Covered Services available to You and Your Dependents under Your dental plan, as well as Your and Your Dependent's costs for each Covered Service. Your and Your Dependent's costs may include Co-Payments, or a percentage of the Maximum Allowed Charge for a Covered Service.

*Care under this plan is provided through a network of Selected General Dentists. Your Selected General Dentist is responsible for determining when the services of a Specialty Care Dentist are needed, and facilitating any necessary referral. If a Specialty Care Dentist is required, You and Your Dependents will be advised of the name, address and telephone number of the Specialty Care Dentist in Your or Your Dependent's Service Area. Your cost for Specialty Care may be higher for a Covered Service than if that Covered Service was provided by Your Selected General Dentist.

Your and Your Dependent's costs for Covered Services provided are calculated using a regional average for the geographic area in which the Covered Services are provided. This may result in a different fee being charged to You based on the geographic area where the Covered Services are provided and may result in a different fee being paid by SafeGuard to Your provider.

Missed Appointments: If You or Your Dependents need to cancel or reschedule an appointment, please notify the Selected General Dental Office as far in advance as possible. This will allow the Selected General Dental Office to accommodate another person in need of attention. If You or Your Dependents fail to do this in a timely fashion, You or Your Dependents may be charged a missed appointment fee.

	Service	Your and Your Dependent's Co-Payment
•	Broken Appointment (less than 24-hr notice)	Not to exceed $25
•	Office visit - per visit (including all fees for sterilization and/or infection control)	$5

Code	Service	Percentage We Cover
	Diagnostic Treatment	
D0120	Periodic oral evaluation - established patient	90%
D0140	Limited oral evaluation - problem focused	90%
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	90%
D0150	Comprehensive oral evaluation - new or established patient	90%
D0160	Detailed and extensive oral evaluation - problem focused, by report	90%
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	90%
D0180	Comprehensive periodontal evaluation - new or established patient	90%
	Radiographs / Diagnostic Imaging (X-rays)	
D0210	Intraoral – complete series (including bitewings)	90%
D0220	Intraoral – periapical first film	90%
D0230	Intraoral – periapical each additional film	90%
D0240	Intraoral – occlusal film	90%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D0250	Extraoral – first film	90%
D0260	Extraoral – each additional film	90%
D0270	Bitewing – single film	90%
D0272	Bitewings – two films	90%
D0273	Bitewings – three films	90%
D0274	Bitewings – four films	90%
D0277	Vertical bitewings – 7 to 8 films	90%
D0330	Panoramic film	90%
D0340	Cephalometric film	90%
D0350	Oral/facial photographic images	90%
D0360	Cone beam ct – craniofacial data capture	50%
D0362	Cone beam – two dimensional image reconstruction using existing data, includes multiple images	50%
D0363	Cone beam – three dimensional image reconstruction using existing data, includes multiple images	50%
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	90%
D0425	Caries susceptibility tests	90%
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	90%
D0460	Pulp vitality tests	90%
D0470	Diagnostic casts	90%
D0472	Accession of tissue, gross examination, preparation and transmission of written report	90%
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	90%
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	90%
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	90%
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	90%
D0502	Other oral pathology procedures, by report	90%
	Preventive Services	
D1110	Prophylaxis – adult	90%
•	Additional-adult prophylaxis	90%
D1120	Prophylaxis – child	90%
•	Additional-child prophylaxis	90%
D1203	Topical application of fluoride – child	90%
D1204	Topical application of fluoride– adult	90%
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	90%
D1310	Nutritional counseling for control of dental disease	90%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D1320	Tobacco counseling for the control and prevention of oral disease	90%
D1330	Oral hygiene instructions	90%
•	Includes periodontal hygiene instruction	
D1351	Sealant – per tooth	70%
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	70%
D1510	Space maintainer – fixed – unilateral	70%
D1515	Space maintainer – fixed – bilateral	70%
D1520	Space maintainer – removable – unilateral	70%
D1525	Space maintainer – removable – bilateral	70%
D1550	Re-cementation of space maintainer	70%
D1555	Removal of fixed space maintainer	70%
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	70%
D2150	Amalgam – two surfaces, primary or permanent	70%
D2160	Amalgam – three surfaces, primary or permanent	70%
D2161	Amalgam – four or more surfaces, primary or permanent	70%
D2330	Resin-based composite – one surface, anterior	70%
D2331	Resin-based composite – two surfaces, anterior	70%
D2332	Resin-based composite – three surfaces, anterior	70%
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	70%
D2390	Resin-based composite crown, anterior	50%
D2391	Resin-based composite – one surface, posterior	70%
D2392	Resin-based composite – two surfaces, posterior	70%
D2393	Resin-based composite – three surfaces, posterior	70%
D2394	Resin-based composite – four or more surfaces, posterior	70%
	Crowns	
•	The cost of porcelain and noble, high noble or titanium metal are included in the Percentage We Cover.	
•	There is no additional charge for full-mouth reconstruction.	
D2510	Inlay – metallic – one surface	50%
D2520	Inlay – metallic – two surfaces	50%
D2530	Inlay – metallic – three or more surfaces	50%
D2542	Onlay – metallic – two surfaces	50%
D2543	Onlay – metallic – three surfaces	50%
D2544	Onlay – metallic – four or more surfaces	50%
D2610	Inlay – porcelain/ceramic – one surface	50%
D2620	Inlay – porcelain/ceramic – two surfaces	50%
D2630	Inlay – porcelain/ceramic – three or more surfaces	50%
D2642	Onlay – porcelain/ceramic – two surfaces	50%
D2643	Onlay – porcelain/ceramic – three surfaces	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D2644	Onlay – porcelain/ceramic – four or more surfaces	50%
D2650	Inlay – resin-based composite – one surface	50%
D2651	Inlay – resin-based composite – two surfaces	50%
D2652	Inlay – resin-based composite – three or more surfaces	50%
D2662	Onlay – resin-based composite – two surfaces	50%
D2663	Onlay – resin-based composite – three surfaces	50%
D2664	Onlay – resin-based composite – four or more surfaces	50%
D2710	Crown – resin-based composite (indirect)	50%
D2712	Crown – ¾ resin-based composite (indirect)	50%
D2720	Crown – resin with high noble metal	50%
D2721	Crown – resin with predominantly base metal	50%
D2722	Crown – resin with noble metal	50%
D2740	Crown – porcelain/ceramic substrate	50%
D2750	Crown – porcelain fused to high noble metal	50%
D2751	Crown – porcelain fused to predominantly base metal	50%
D2752	Crown – porcelain fused to noble metal	50%
D2780	Crown – ¾ cast high noble metal	50%
D2781	Crown – ¾ cast predominantly base metal	50%
D2782	Crown – ¾ cast noble metal	50%
D2783	Crown – ¾ porcelain/ceramic	50%
D2790	Crown – full cast high noble metal	50%
D2791	Crown – full cast predominantly base metal	50%
D2792	Crown – full cast noble metal	50%
D2794	Crown – titanium	50%
D2799	Provisional crown	50%
D2910	Recement inlay, onlay, or partial coverage restoration	50%
D2915	Recement cast or prefabricated post and core	50%
D2920	Recement crown	50%
D2930	Prefabricated stainless steel crown – primary tooth	50%
D2931	Prefabricated stainless steel crown – permanent tooth	50%
D2932	Prefabricated resin crown	50%
D2933	Prefabricated stainless steel crown with resin window	50%
D2940	Protective restoration	70%
D2950	Core buildup, including any pins	50%
D2951	Pin retention – per tooth, in addition to restoration	50%
D2952	Post and core in addition to crown, indirectly fabricated	50%
D2953	Each additional indirectly fabricated post – same tooth	50%
D2954	Prefabricated post and core in addition to crown	50%
D2955	Post removal (not in conjunction with endodontic therapy)	50%
D2957	Each additional prefabricated post – same tooth	50%
D2960	Labial veneer (resin laminate) – chairside	50%
D2961	Labial veneer (resin laminate) – laboratory	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D2962	Labial veneer (porcelain laminate) – laboratory	50%
D2970	Temporary crown (fractured tooth)	100%
D2971	Additional procedures to construct new crown under existing partial denture framework	50%
D2980	Crown repair, by report	100%
	Endodontics	
•	All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	70%
D3120	Pulp cap – indirect (excluding final restoration)	70%
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	70%
D3221	Pulpal debridement, primary and permanent teeth	70%
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	70%
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	70%
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	70%
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	50%
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	50%
D3330	Endodontic therapy, molar tooth (excluding final restoration)	50%
D3331	Treatment of root canal obstruction; non-surgical access	50%
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%
D3333	Internal root repair of perforation defects	50%
D3346	Retreatment of previous root canal therapy – anterior	50%
D3347	Retreatment of previous root canal therapy – bicuspid	50%
D3348	Retreatment of previous root canal therapy – molar	50%
D3351	Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	50%
D3352	Apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	50%
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	50%
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	50%
D3410	Apicoectomy/periradicular surgery – anterior	50%
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	50%
D3425	Apicoectomy/periradicular surgery – molar (first root)	50%
D3426	Apicoectomy/periradicular surgery (each additional root)	50%
D3430	Retrograde filling – per root	50%
D3450	Root amputation – per root	50%
D3460	Endodontic endosseous implant	50%
D3910	Surgical procedure for isolation of tooth with rubber dam	100%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D3920	Hemisection (including any root removal), not including root canal therapy	50%
D3950	Canal preparation and fitting of preformed dowel or post	50%
	Periodontics	
•	Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	50%
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	50%
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	50%
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	50%
D4245	Apically positioned flap	50%
D4249	Clinical crown lengthening – hard tissue	50%
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	50%
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	50%
D4263	Bone replacement graft – first site in quadrant	50%
D4264	Bone replacement graft – each additional site in quadrant	50%
D4265	Biologic materials to aid in soft and osseous tissue regeneration	50%
D4266	Guided tissue regeneration – resorbable barrier, per site	50%
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	50%
D4268	Surgical revision procedure, per tooth	100%
D4270	Pedicle soft tissue graft procedure	50%
D4271	Free soft tissue graft procedure (including donor site surgery)	50%
D4273	Subepithelial connective tissue graft procedures, per tooth	50%
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	50%
D4275	Soft tissue allograft	50%
D4276	Combined connective tissue and double pedicle graft, per tooth	50%
D4320	Provisional splinting – intracoronal	50%
D4321	Provisional splinting – extracoronal	50%
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	70%
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	70%
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	70%
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	70%
D4910	Periodontal maintenance	70%
D4920	Unscheduled dressing change (by someone other than treating dentist)	100%
•	Additional periodontal maintenance procedures (beyond 2 per 12 months)	70%
	Removable Prosthodontics	

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
•	Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service.	
D5110	Complete denture – maxillary	50%
D5120	Complete denture – mandibular	50%
D5130	Immediate denture – maxillary	50%
D5140	Immediate denture – mandibular	50%
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	50%
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	50%
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	50%
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	50%
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	50%
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	50%
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	50%
D5410	Adjust complete denture – maxillary	70%
D5411	Adjust complete denture – mandibular	70%
D5421	Adjust partial denture – maxillary	70%
D5422	Adjust partial denture – mandibular	70%
D5510	Repair broken complete denture base	50%
D5520	Replace missing or broken teeth – complete denture (each tooth)	50%
D5610	Repair resin denture base	50%
D5620	Repair cast framework	50%
D5630	Repair or replace broken clasp	50%
D5640	Replace broken teeth – per tooth	50%
D5650	Add tooth to existing partial denture	50%
D5660	Add clasp to existing partial denture	50%
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	50%
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	50%
D5710	Rebase complete maxillary denture	50%
D5711	Rebase complete mandibular denture	50%
D5720	Rebase maxillary partial denture	50%
D5721	Rebase mandibular partial denture	50%
D5730	Reline complete maxillary denture (chairside)	50%
D5731	Reline complete mandibular denture (chairside)	50%
D5740	Reline maxillary partial denture (chairside)	50%
D5741	Reline mandibular partial denture (chairside)	50%
D5750	Reline complete maxillary denture (laboratory)	50%
D5751	Reline complete mandibular denture (laboratory)	50%
D5760	Reline maxillary partial denture (laboratory)	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D5761	Reline mandibular partial denture (laboratory)	50%
D5810	Interim complete denture (maxillary)	50%
D5811	Interim complete denture (mandibular)	50%
D5820	Interim partial denture (maxillary)	50%
D5821	Interim partial denture (mandibular)	50%
D5850	Tissue conditioning, maxillary	50%
D5851	Tissue conditioning, mandibular	50%
D5862	Precision attachment, by report	50%
	Implant Services	
	Pre-Surgical Services	
D6190	Radiographic/surgical implant index, by report	50%
	Surgical Services	
D6010	Surgical placement of implant body; endosteal implant	50%
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	50%
D6040	Surgical placement: eposteal implant	50%
D6050	Surgical placement: transosteal implant	50%
D6100	Implant removal, by report	50%
	Implant Supported Prosthetics	
•	The cost of porcelain and noble, high noble or titanium metal are included in the Percentage We Cover.	
•	There is no additional charge for full-mouth reconstruction.	
D6053	Implant/abutment supported removable denture for completely endentulous arch	50%
D6054	Implant/abutment supported removable denture for partially endentulous arch	50%
D6055	Connecting bar -- implant supported or abutment supported	50%
D6056	Prefabricated abutment – includes placement	50%
D6057	Custom abutment – includes placement	50%
D6058	Abutment supported porcelain/ceramic crown	50%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	50%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	50%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	50%
D6062	Abutment supported cast metal crown (high noble metal)	50%
D6063	Abutment supported cast metal crown (predominantly base metal)	50%
D6064	Abutment supported cast metal crown (noble metal)	50%
D6065	Implant supported porcelain/ceramic crown	50%
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	50%
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	50%
D6068	Abutment supported retainer for porcelain/ceramic FPD	50%
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	50%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	50%
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	50%
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	50%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	50%
D6075	Implant supported retainer for ceramic FPD	50%
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	50%
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	50%
D6078	Implant/abutment supported fixed denture for completely edentulous arch	50%
D6079	Implant/abutment supported fixed denture for partially edentulous arch	50%
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	50%
D6090	Repair implant supported prosthesis, by report	50%
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	50%
D6092	Recement implant/abutment supported crown	50%
D6093	Recement implant/abutment supported fixed partial denture	50%
D6094	Abutment supported crown (titanium)	50%
D6095	Repair implant abutment, by report	50%
D6194	Abutment supported retainer crown for FPD (titanium)	50%
	Crowns/Fixed Bridges - Per Unit	
•	The cost of porcelain and noble, high noble or titanium metal are included in the Percentage We Cover.	
•	There is no additional charge for full-mouth reconstruction.	
D6205	Pontic – indirect resin based composite	50%
D6210	Pontic – cast high noble metal	50%
D6211	Pontic – cast predominantly base metal	50%
D6212	Pontic – cast noble metal	50%
D6214	Pontic – titanium	50%
D6240	Pontic – porcelain fused to high noble metal	50%
D6241	Pontic – porcelain fused to predominantly base metal	50%
D6242	Pontic – porcelain fused to noble metal	50%
D6245	Pontic – porcelain/ceramic	50%
D6250	Pontic – resin with high noble metal	50%
D6251	Pontic – resin with predominantly base metal	50%
D6252	Pontic – resin with noble metal	50%
D6253	Provisional pontic	50%
D6254	Interim pontic	50%
D6545	Retainer – cast metal for resin bonded fixed prosthesis	50%
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D6600	Inlay – porcelain/ceramic, two surfaces	50%
D6601	Inlay – porcelain/ceramic, three or more surfaces	50%
D6602	Inlay – cast high noble metal, two surfaces	50%
D6603	Inlay – cast high noble metal, three or more surfaces	50%
D6604	Inlay – cast predominantly base metal, two surfaces	50%
D6605	Inlay – cast predominantly base metal, three or more surfaces	50%
D6606	Inlay – cast noble metal, two surfaces	50%
D6607	Inlay – cast noble metal, three or more surfaces	50%
D6608	Onlay – porcelain/ceramic, two surfaces	50%
D6609	Onlay – porcelain/ceramic, three or more surfaces	50%
D6610	Onlay – cast high noble metal, two surfaces	50%
D6611	Onlay – cast high noble metal, three or more surfaces	50%
D6612	Onlay – cast predominantly base metal, two surfaces	50%
D6613	Onlay – cast predominantly base metal, three or more surfaces	50%
D6614	Onlay – cast noble metal, two surfaces	50%
D6615	Onlay – cast noble metal, three or more surfaces	50%
D6624	Inlay – titanium	50%
D6634	Onlay – titanium	50%
D6710	Crown – indirect resin based composite	50%
D6720	Crown – resin with high noble metal	50%
D6721	Crown – resin with predominantly base metal	50%
D6722	Crown – resin with noble metal	50%
D6740	Crown – porcelain/ceramic	50%
D6750	Crown – porcelain fused to high noble metal	50%
D6751	Crown – porcelain fused to predominantly base metal	50%
D6752	Crown – porcelain fused to noble metal	50%
D6780	Crown – ¾ cast high noble metal	50%
D6781	Crown – ¾ cast predominantly base metal	50%
D6782	Crown – ¾ cast noble metal	50%
D6783	Crown – ¾ porcelain/ceramic	50%
D6790	Crown – full cast high noble metal	50%
D6791	Crown – full cast predominantly base metal	50%
D6792	Crown – full cast noble metal	50%
D6793	Provisional retainer crown	50%
D6794	Crown – titanium	50%
D6795	Interim retainer crown	50%
D6930	Recement fixed partial denture	50%
D6940	Stress breaker	50%
D6950	Precision attachment	50%
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	50%
D6972	Prefabricated post and core in addition to fixed partial denture retainer	50%
D6973	Core build up for retainer, including any pins	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D6976	Each additional indirectly fabricated post – same tooth	50%
D6977	Each additional prefabricated post – same tooth	50%
D6980	Fixed partial denture repair, by report	50%
	Oral Surgery	
•	Includes routine post operative visits/treatment.	
•	The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists.	
D7111	Extraction, coronal remnants – deciduous tooth	70%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	70%
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	70%
D7220	Removal of impacted tooth – soft tissue	70%
D7230	Removal of impacted tooth – partially bony	70%
D7240	Removal of impacted tooth – completely bony	70%
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	70%
D7250	Surgical removal of residual tooth roots (cutting procedure)	70%
D7251	Coronectomy – intentional partial tooth removal	70%
D7260	Oroantral fistula closure	50%
D7261	Primary closure of a sinus perforation	50%
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%
D7280	Surgical access of an unerupted tooth	50%
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%
D7285	Biopsy of oral tissue – hard (bone, tooth)	50%
D7286	Biopsy of oral tissue – soft	50%
D7287	Exfoliative cytological sample collection	50%
D7288	Brush biopsy – transepithelial sample collection	50%
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	50%
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	50%
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	50%
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	50%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	50%
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	50%
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	50%
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	50%
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	50%

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
D7471	Removal of lateral exostosis (maxilla or mandible)	50%
D7472	Removal of torus palatinus	50%
D7473	Removal of torus mandibularis	50%
D7485	Surgical reduction of osseous tuberosity	50%
D7510	Incision and drainage of abscess – intraoral soft tissue	50%
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	50%
D7520	Incision and drainage of abscess – extraoral soft tissue	50%
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	50%
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	50%
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%
D7910	Suture of recent small wounds up to 5 cm	50%
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	50%
D7951	Sinus augmentation with bone or bone substitutes	50%
D7953	Bone replacement graft for ridge preservation – per site	50%
D7960	Frenulectomy – also known as (frenectomy or frenotomy) – separate procedure not incidental to another procedure	50%
D7963	Frenuloplasty	50%
D7970	Excision of hyperplastic tissue – per arch	50%
D7971	Excision of pericoronal gingiva	50%
D7972	Surgical reduction of fibrous tuberosity	50%
	Orthodontics	
•	Benefits cover twenty-four (24) months of usual & customary Orthodontic treatment and an additional twenty-four (24) months of retention.	
•	Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances.	
D8010	Limited orthodontic treatment of the primary dentition	50%
D8020	Limited orthodontic treatment of the transitional dentition	50%
D8030	Limited orthodontic treatment of the adolescent dentition	50%
D8040	Limited orthodontic treatment of the adult dentition	50%
D8070	Comprehensive orthodontic treatment of the transitional dentition	50%
D8080	Comprehensive orthodontic treatment of the adolescent dentition	50%
D8090	Comprehensive orthodontic treatment of the adult dentition	50%
D8660	Pre-orthodontic treatment visit	100%
D8670	Periodic orthodontic treatment visit (as part of contract)	100%
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	50%
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	50%
•	There is a Co-Payment of $250 for Orthodontic treatment planning and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models).	
•	There is a Co-Payment of $25 per visit for Orthodontic visits beyond twenty-four (24) months of active treatment or retention.	

SCHEDULE OF BENEFITS (continued)

Code	Service	Percentage We Cover
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	70%
D9120	Fixed partial denture sectioning	50%
D9210	Local anesthesia not in conjunction with operative or surgical procedures	100%
D9211	Regional block anesthesia	100%
D9212	Trigeminal division block anesthesia	100%
D9215	Local anesthesia in conjunction with operative or surgical procedures	100%
D9220	Deep sedation/general anesthesia – first 30 minutes	50%
D9221	Deep sedation/general anesthesia – each additional 15 minutes	50%
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	70%
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	50%
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	50%
D9248	Non-intravenous conscious sedation	70%
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	100%
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	100%
D9440	Office visit – after regularly scheduled hours	70%
D9450	Case presentation, detailed and extensive treatment planning	100%
D9610	Therapeutic parenteral drug, single administration	70%
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	70%
D9630	Other drugs and/or medicaments, by report	70%
D9910	Application of desensitizing medicament	70%
D9930	Treatment of complication (post-surgical) – unusual circumstances, by report	100%
D9940	Occlusal guard, by report	50%
D9942	Repair and/or reline of occlusal guard	50%
D9951	Occlusal adjustment – limited	50%
D9952	Occlusal adjustment – complete	50%

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

General

1. Specialty Care Dentists will accept the contracted fee for all Covered Services.

2. General anesthesia or IV sedation is a Covered Service only if it is provided in a Selected General Dental Office, administered by the Selected General Dentist or Specialty Care Dentist, and is in conjunction with covered oral and periodontal surgical procedures or when deemed necessary by the Selected General Dentist or Specialty Care Dentist.

3. Sterilization and infection control are not billable to Us or You or Your Dependent and are included within the charges for other services provided on that date of service.
    a. Local Anesthetic is included in all restorative and surgical procedure fees.
    b. All adhesives, liners, bases and occlusal adjustments are included as a part of the restorative procedure.

Diagnostic

1. Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.

2. All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

1. Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. Additional cleanings (routine and periodontal) are available at the Selected General Dentist or Specialty Care Dentist in accordance with the SCHEDULE OF BENEFITS. Additional Prophylaxis are available, if Dentally Necessary.

2. Sealants and/or preventive resin restorations: Plan benefit applies to primary and permanent molar teeth, limited to age 19, one (1) per tooth, per thirty-six (36) months, unless Dentally Necessary.

3. Space maintainers are covered to age 14 once per area, per lifetime. Replacement of lost space maintainers are not a Covered Service.

Restorative Treatment

Crowns, Implants and Fixed Bridges:

1. The cost of porcelain and noble, high noble or titanium metal are included in the listed Percentage We Cover amount.

2. There is no additional charge for full-mouth reconstruction.

3. Prefabricated stainless steel Crowns or prefabricated resin Crowns are limited to no more than one (1) replacement for the same tooth surface within five (5) years.

4. Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.

5. Provisional Crowns/restorations are to be used for an interim of at least six (6) months duration. Interim crowns/restorations are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.

6. Replacement of any Cast Restorations with the same or a different type of Cast Restoration are limited to no more than once every five (5) years.

7. Core buildups are limited to no more than once per tooth in a period of five (5) years.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

8. Post and cores are limited to no more than once per tooth in a period of five (5) years.

9. Labial veneers are limited to no more than once per tooth in a period of five (5) years.

Prosthodontics

1. Relinings and rebasings are limited to one (1) every twelve (12) months.

2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist or Specialty Care Dentist.

3. Replacement of an immediate full Denture with a permanent full Denture if the immediate full Denture cannot be made permanent and such replacement is done within twelve (12) months of the installation of the immediate full Denture.

4. Adjustments of Dentures if at least six (6) months have passed since the installation of the existing removable Denture.

5. Delivery of removable and fixed Prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

6. Tissue conditioning eligible one (1) per appliance each twenty-four (24) months.

7. Provisional prostheses are to be used for an interim of at least six (6) months duration. Interim prostheses are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.

Implant Services

1. Implants are limited to no more than once for the same tooth position in a five (5) year period.

2. Repairs of implants are limited to not more than once in a twelve (12) month period.

3. Implant supported prosthetics are limited to no more than once for the same tooth position in a five (5) year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

4. The following are limited to no more than two (2) each per year: Implants, Implant supported prosthetics, and Implant abutments.

Endodontics

1. The Percentage We Cover listed for Endodontic procedures does not include the cost of the final restoration.

2. Materials used for canal irrigation are included in the Endodontic procedure fees.

Oral Surgery

1. The removal of asymptomatic third molars is not a Covered Service. Pathology (disease) must exist for it to be covered by the program.

2. Includes routine post operative visits/treatments.

Periodontics

1. Irrigation (such as Chlorhexidine), is included with the other services rendered that day.

2. Local chemotherapeutic agents are limited to no more than six (6) teeth per arch. Treatment plans involving more than six (6) teeth per arch, require prior Plan approval.

3. Periodontal maintenance is eligible following active periodontal therapy, which includes scaling and root planing, surgery, etc.

4. Periodontal scaling and root planing, is limited to not more than once per Quadrant in any twenty-four (24) month period.

5. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.

6. Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.

Orthodontics

1. If You or Your Dependent require the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.

2. If You or Your Dependent terminate coverage from the SafeGuard Plan after the start of Orthodontic treatment, You will be responsible for any additional charges incurred for the remaining Orthodontic treatment.

3. Orthodontic treatment must be provided by a Selected General Dentist or Specialty Care Dentist whose specialty is orthodontics or pediatric dentistry for the Percentage We Cover listed in this SCHEDULE OF BENEFITS to apply.

4. Plan benefits shall cover twenty-four (24) months of usual and customary Orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.

5. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

6. Continuing Orthodontic treatment is available if You or Your Dependent qualify by enrolling within 30 days of the Effective Date for an eligible policyholder; You or Your Dependent had Orthodontic coverage under the policyholder's prior plan and were in active Orthodontic treatment, covered by that Plan, as of the Effective Date of this group contract. Upon receipt of a completed Continuing Orthodontic Form by Us, with all supporting documentation, We will accept liability for continuing payment of the remaining balance owed, up to a maximum of $1,500 times the percentage of the total treatment remaining as of this group contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS. The Continuing Orthodontic provision is not available:
    - thirty (30) days after this group contract's Effective Date;
    - to a person who enrolls after the group contract's Effective Date; or
    - to a person who is not in active Orthodontic treatment as of the Effective Date of this group contract.

DENTAL BENEFITS: EXCLUSIONS

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS), are not covered.

2. Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS (except for out-of-area emergency services).

3. Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (the tooth has been opened into the pulp (nerve chamber)), or full or partial Dentures for which an impression has been taken.

4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.

5. Orthognathic surgery.

6. Inpatient/outpatient hospital charges of any kind, including prescriptions or medications. General anesthesia or IV sedation is not covered for any reason if rendered in an out patient facility or hospital. Dental charges will be covered, if the procedure performed is covered by the Plan.

7. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.

8. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.

9. Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.

10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

11. Dental services required while serving in the armed forces of any country or international authority.

12. Dental services considered Experimental in nature.

13. Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.

14. The following are not included as Orthodontic benefits:
    - Repair or replacement of lost or broken appliances;
    - Retreatment of Orthodontic cases;
    - Treatment involving:
        - Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
        - Hormonal imbalances or other factors affecting growth or developmental abnormalities;
        - Treatment related to temporomandibular joint disorders;
    - Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded.

LANGUAGE ASSISTANCE

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at (800) 880-1800.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al (800) 880-1800.

作為**SafeGuard**的會員，您有權獲得免費語言服務，包括口譯和筆譯。**SafeGuard**收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴**SafeGuard**，可通過電話或網站與**SafeGuard**聯絡，電話是**(800) 880-1800**。