



SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan*

METCO7C

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 | 100% |
| D0140 | Limited oral evaluation - problem focused | 100% |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | 100% |
| D0150 | Comprehensive oral evaluation - new or established patient | 100% |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | 100% |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | 100% |
| D0180 | Comprehensive periodontal evaluation - new or established patient | 100% |
| Radiographs / Diagnostic Imaging (X-rays) | | |
| D0210 | Intraoral – complete series (including bitewings) | 100% |
| D0220 | Intraoral – periapical first film | 100% |
| D0230 | Intraoral – periapical each additional film | 100% |
| D0240 | Intraoral – occlusal film | 100% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------------------------------|---|----------------------------|
| D0250 | Extraoral – first film | 100% |
| D0260 | Extraoral – each additional film | 100% |
| D0270 | Bitewing – single film | 100% |
| D0272 | Bitewings – two films | 100% |
| D0273 | Bitewings – three films | 100% |
| D0274 | Bitewings – four films | 100% |
| D0277 | Vertical bitewings – 7 to 8 films | 100% |
| D0330 | Panoramic film | 100% |
| D0340 | Cephalometric film | 100% |
| D0350 | Oral/facial photographic images | 100% |
| D0360 | Cone beam ct – craniofacial data capture | 60% |
| D0362 | Cone beam – two dimensional image reconstruction using existing data, includes multiple images | 60% |
| D0363 | Cone beam – three dimensional image reconstruction using existing data, includes multiple images | 60% |
| Tests and Examinations | | |
| D0415 | Collection of microorganisms for culture and sensitivity | 100% |
| D0425 | Caries susceptibility tests | 100% |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | 100% |
| D0460 | Pulp vitality tests | 100% |
| D0470 | Diagnostic casts | 100% |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | 100% |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | 100% |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | 100% |
| D0480 | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report | 100% |
| D0486 | Accession of brush biopsytransepithelial cytologic sample, microscopic examination, preparation and transmission of written report | 100% |
| D0502 | Other oral pathology procedures, by report | 100% |
| Preventive Services | | |
| D1110 | Prophylaxis – adult | 100% |
| | • Additional-adult prophylaxis | 100% |
| D1120 | Prophylaxis – child | 100% |
| | • Additional-child prophylaxis | 100% |
| D1203 | Topical application of fluoride – child | 100% |
| D1204 | Topical application of fluoride– adult | 100% |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients | 100% |
| D1310 | Nutritional counseling for control of dental disease | 100% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|------------------------------|--|---------------------|
| D1320 | Tobacco counseling for the control and prevention of oral disease | 100% |
| D1330 | Oral hygiene instructions | 100% |
| | • Includes periodontal hygiene instruction | |
| D1351 | Sealant – per tooth | 90% |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient – permanent tooth | 90% |
| D1510 | Space maintainer – fixed – unilateral | 90% |
| D1515 | Space maintainer – fixed – bilateral | 90% |
| D1520 | Space maintainer – removable – unilateral | 90% |
| D1525 | Space maintainer – removable – bilateral | 90% |
| D1550 | Re-cementation of space maintainer | 90% |
| D1555 | Removal of fixed space maintainer | 90% |
| Restorative Treatment | | |
| D2140 | Amalgam – one surface, primary or permanent | 90% |
| D2150 | Amalgam – two surfaces, primary or permanent | 90% |
| D2160 | Amalgam – three surfaces, primary or permanent | 90% |
| D2161 | Amalgam – four or more surfaces, primary or permanent | 90% |
| D2330 | Resin-based composite – one surface, anterior | 90% |
| D2331 | Resin-based composite – two surfaces, anterior | 90% |
| D2332 | Resin-based composite – three surfaces, anterior | 90% |
| D2335 | Resin-based composite – four or more surfaces or involving incisal angle (anterior) | 90% |
| D2390 | Resin-based composite crown, anterior | 60% |
| D2391 | Resin-based composite – one surface, posterior | 90% |
| D2392 | Resin-based composite – two surfaces, posterior | 90% |
| D2393 | Resin-based composite – three surfaces, posterior | 90% |
| D2394 | Resin-based composite – four or more surfaces, posterior | 90% |
| 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 | 60% |
| D2520 | Inlay – metallic – two surfaces | 60% |
| D2530 | Inlay – metallic – three or more surfaces | 60% |
| D2542 | Onlay – metallic – two surfaces | 60% |
| D2543 | Onlay – metallic – three surfaces | 60% |
| D2544 | Onlay – metallic – four or more surfaces | 60% |
| D2610 | Inlay – porcelain/ceramic – one surface | 60% |
| D2620 | Inlay – porcelain/ceramic – two surfaces | 60% |
| D2630 | Inlay – porcelain/ceramic – three or more surfaces | 60% |
| D2642 | Onlay – porcelain/ceramic – two surfaces | 60% |
| D2643 | Onlay – porcelain/ceramic – three surfaces | 60% |
| D2644 | Onlay – porcelain/ceramic – four or more surfaces | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------|---|---------------------|
| D2650 | Inlay – resin-based composite – one surface | 60% |
| D2651 | Inlay – resin-based composite – two surfaces | 60% |
| D2652 | Inlay – resin-based composite – three or more surfaces | 60% |
| D2662 | Onlay – resin-based composite – two surfaces | 60% |
| D2663 | Onlay – resin-based composite – three surfaces | 60% |
| D2664 | Onlay – resin-based composite – four or more surfaces | 60% |
| D2710 | Crown – resin-based composite (indirect) | 60% |
| D2712 | Crown – ¾ resin-based composite (indirect) | 60% |
| D2720 | Crown – resin with high noble metal | 60% |
| D2721 | Crown – resin with predominantly base metal | 60% |
| D2722 | Crown – resin with noble metal | 60% |
| D2740 | Crown – porcelain/ceramic substrate | 60% |
| D2750 | Crown – porcelain fused to high noble metal | 60% |
| D2751 | Crown – porcelain fused to predominantly base metal | 60% |
| D2752 | Crown – porcelain fused to noble metal | 60% |
| D2780 | Crown – ¾ cast high noble metal | 60% |
| D2781 | Crown – ¾ cast predominantly base metal | 60% |
| D2782 | Crown – ¾ cast noble metal | 60% |
| D2783 | Crown – ¾ porcelain/ceramic | 60% |
| D2790 | Crown – full cast high noble metal | 60% |
| D2791 | Crown – full cast predominantly base metal | 60% |
| D2792 | Crown – full cast noble metal | 60% |
| D2794 | Crown – titanium | 60% |
| D2799 | Provisional crown | 60% |
| D2910 | Recement inlay, onlay, or partial coverage restoration | 60% |
| D2915 | Recement cast or prefabricated post and core | 60% |
| D2920 | Recement crown | 60% |
| D2930 | Prefabricated stainless steel crown – primary tooth | 60% |
| D2931 | Prefabricated stainless steel crown – permanent tooth | 60% |
| D2932 | Prefabricated resin crown | 60% |
| D2933 | Prefabricated stainless steel crown with resin window | 60% |
| D2940 | Protective restoration | 90% |
| D2950 | Core buildup, including any pins | 60% |
| D2951 | Pin retention – per tooth, in addition to restoration | 60% |
| D2952 | Post and core in addition to crown, indirectly fabricated | 60% |
| D2953 | Each additional indirectly fabricated post – same tooth | 60% |
| D2954 | Prefabricated post and core in addition to crown | 60% |
| D2955 | Post removal (not in conjunction with endodontic therapy) | 60% |
| D2957 | Each additional prefabricated post – same tooth | 60% |
| D2960 | Labial veneer (resin laminate) – chairside | 60% |
| D2961 | Labial veneer (resin laminate) – laboratory | 60% |
| D2962 | Labial veneer (porcelain laminate) – laboratory | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|--------------------|--|---------------------|
| D2970 | Temporary crown (fractured tooth) | 100% |
| D2971 | Additional procedures to construct new crown under existing partial denture framework | 60% |
| D2980 | Crown repair, by report | 100% |
| Endodontics | | |
| • | All procedures exclude final restoration. | |
| D3110 | Pulp cap – direct (excluding final restoration) | 90% |
| D3120 | Pulp cap – indirect (excluding final restoration) | 90% |
| D3220 | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | 90% |
| D3221 | Pulpal debridement, primary and permanent teeth | 90% |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | 90% |
| D3230 | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) | 90% |
| D3240 | Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) | 90% |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | 60% |
| D3320 | Endodontic therapy, bicuspid tooth (excluding final restoration) | 60% |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | 60% |
| D3331 | Treatment of root canal obstruction; non-surgical access | 60% |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | 60% |
| D3333 | Internal root repair of perforation defects | 60% |
| D3346 | Retreatment of previous root canal therapy – anterior | 60% |
| D3347 | Retreatment of previous root canal therapy – bicuspid | 60% |
| D3348 | Retreatment of previous root canal therapy – molar | 60% |
| D3351 | Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.) | 60% |
| D3352 | Apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.) | 60% |
| D3353 | Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calific repair of perforations, root resorption, etc.) | 60% |
| D3354 | Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration | 60% |
| D3410 | Apicoectomy/periradicular surgery – anterior | 60% |
| D3421 | Apicoectomy/periradicular surgery – bicuspid (first root) | 60% |
| D3425 | Apicoectomy/periradicular surgery – molar (first root) | 60% |
| D3426 | Apicoectomy/periradicular surgery (each additional root) | 60% |
| D3430 | Retrograde filling – per root | 60% |
| D3450 | Root amputation – per root | 60% |
| D3460 | Endodontic endosseous implant | 60% |
| D3910 | Surgical procedure for isolation of tooth with rubber dam | 100% |
| D3920 | Hemisection (including any root removal), not including root canal therapy | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|---------------------------------|--|---------------------|
| D3950 | Canal preparation and fitting of preformed dowel or post | 60% |
| Periodontics | | |
| | <ul style="list-style-type: none"> 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 | 60% |
| D4211 | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant | 60% |
| D4240 | Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant | 60% |
| D4241 | Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant | 60% |
| D4245 | Apically positioned flap | 60% |
| D4249 | Clinical crown lengthening – hard tissue | 60% |
| D4260 | Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | 60% |
| D4261 | Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | 60% |
| D4263 | Bone replacement graft – first site in quadrant | 60% |
| D4264 | Bone replacement graft – each additional site in quadrant | 60% |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | 60% |
| D4266 | Guided tissue regeneration – resorbable barrier, per site | 60% |
| D4267 | Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal) | 60% |
| D4268 | Surgical revision procedure, per tooth | 100% |
| D4270 | Pedicle soft tissue graft procedure | 60% |
| D4271 | Free soft tissue graft procedure (including donor site surgery) | 60% |
| D4273 | Subepithelial connective tissue graft procedures, per tooth | 60% |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | 60% |
| D4275 | Soft tissue allograft | 60% |
| D4276 | Combined connective tissue and double pedicle graft, per tooth | 60% |
| D4320 | Provisional splinting – intracoronal | 60% |
| D4321 | Provisional splinting – extracoronal | 60% |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | 90% |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant | 90% |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | 90% |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report | 90% |
| D4910 | Periodontal maintenance | 90% |
| D4920 | Unscheduled dressing change (by someone other than treating dentist) | 100% |
| | <ul style="list-style-type: none"> Additional periodontal maintenance procedures (beyond 2 per 12 months) | 90% |
| Removable Prosthodontics | | |
| | <ul style="list-style-type: none"> Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service. | |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------------|---|----------------------------|
| D5110 | Complete denture – maxillary | 60% |
| D5120 | Complete denture – mandibular | 60% |
| D5130 | Immediate denture – maxillary | 60% |
| D5140 | Immediate denture – mandibular | 60% |
| D5211 | Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | 60% |
| D5212 | Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | 60% |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 60% |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 60% |
| D5225 | Maxillary partial denture – flexible base (including any clasps, rests and teeth) | 60% |
| D5226 | Mandibular partial denture – flexible base (including any clasps, rests and teeth) | 60% |
| D5281 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth) | 60% |
| D5410 | Adjust complete denture – maxillary | 90% |
| D5411 | Adjust complete denture – mandibular | 90% |
| D5421 | Adjust partial denture – maxillary | 90% |
| D5422 | Adjust partial denture – mandibular | 90% |
| D5510 | Repair broken complete denture base | 60% |
| D5520 | Replace missing or broken teeth – complete denture (each tooth) | 60% |
| D5610 | Repair resin denture base | 60% |
| D5620 | Repair cast framework | 60% |
| D5630 | Repair or replace broken clasp | 60% |
| D5640 | Replace broken teeth – per tooth | 60% |
| D5650 | Add tooth to existing partial denture | 60% |
| D5660 | Add clasp to existing partial denture | 60% |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | 60% |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | 60% |
| D5710 | Rebase complete maxillary denture | 60% |
| D5711 | Rebase complete mandibular denture | 60% |
| D5720 | Rebase maxillary partial denture | 60% |
| D5721 | Rebase mandibular partial denture | 60% |
| D5730 | Reline complete maxillary denture (chairside) | 60% |
| D5731 | Reline complete mandibular denture (chairside) | 60% |
| D5740 | Reline maxillary partial denture (chairside) | 60% |
| D5741 | Reline mandibular partial denture (chairside) | 60% |
| D5750 | Reline complete maxillary denture (laboratory) | 60% |
| D5751 | Reline complete mandibular denture (laboratory) | 60% |
| D5760 | Reline maxillary partial denture (laboratory) | 60% |
| D5761 | Reline mandibular partial denture (laboratory) | 60% |
| D5810 | Interim complete denture (maxillary) | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|--------------------------------------|--|----------------------------|
| D5811 | Interim complete denture (mandibular) | 60% |
| D5820 | Interim partial denture (maxillary) | 60% |
| D5821 | Interim partial denture (mandibular) | 60% |
| D5850 | Tissue conditioning, maxillary | 60% |
| D5851 | Tissue conditioning, mandibular | 60% |
| D5862 | Precision attachment, by report | 60% |
| Implant Services | | |
| Pre-Surgical Services | | |
| D6190 | Radiographic/surgical implant index, by report | 60% |
| Surgical Services | | |
| D6010 | Surgical placement of implant body; endosteal implant | 60% |
| D6012 | Surgical placement of interim implant body for transitional prosthesis: endosteal implant | 60% |
| D6040 | Surgical placement: eposteal implant | 60% |
| D6050 | Surgical placement: transosteal implant | 60% |
| D6100 | Implant removal, by report | 60% |
| Implant Supported Prosthetics | | |
| | <ul style="list-style-type: none"> • 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 edentulous arch | 60% |
| D6054 | Implant/abutment supported removable denture for partially edentulous arch | 60% |
| D6055 | Connecting bar -- implant supported or abutment supported | 60% |
| D6056 | Prefabricated abutment – includes placement | 60% |
| D6057 | Custom abutment – includes placement | 60% |
| D6058 | Abutment supported porcelain/ceramic crown | 60% |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | 60% |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | 60% |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | 60% |
| D6062 | Abutment supported cast metal crown (high noble metal) | 60% |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | 60% |
| D6064 | Abutment supported cast metal crown (noble metal) | 60% |
| D6065 | Implant supported porcelain/ceramic crown | 60% |
| D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | 60% |
| D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | 60% |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | 60% |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | 60% |
| D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | 60% |
| D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|--|--|---------------------|
| D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | 60% |
| D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | 60% |
| D6074 | Abutment supported retainer for cast metal FPD (noble metal) | 60% |
| D6075 | Implant supported retainer for ceramic FPD | 60% |
| D6076 | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) | 60% |
| D6077 | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) | 60% |
| D6078 | Implant/abutment supported fixed denture for completely edentulous arch | 60% |
| D6079 | Implant/abutment supported fixed denture for partially edentulous arch | 60% |
| D6080 | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis | 60% |
| D6090 | Repair implant supported prosthesis, by report | 60% |
| D6091 | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | 60% |
| D6092 | Recement implant/abutment supported crown | 60% |
| D6093 | Recement implant/abutment supported fixed partial denture | 60% |
| D6094 | Abutment supported crown (titanium) | 60% |
| D6095 | Repair implant abutment, by report | 60% |
| D6194 | Abutment supported retainer crown for FPD (titanium) | 60% |
| Crowns/Fixed Bridges - Per Unit | | |
| | <ul style="list-style-type: none"> 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 | 60% |
| D6210 | Pontic – cast high noble metal | 60% |
| D6211 | Pontic – cast predominantly base metal | 60% |
| D6212 | Pontic – cast noble metal | 60% |
| D6214 | Pontic – titanium | 60% |
| D6240 | Pontic – porcelain fused to high noble metal | 60% |
| D6241 | Pontic – porcelain fused to predominantly base metal | 60% |
| D6242 | Pontic – porcelain fused to noble metal | 60% |
| D6245 | Pontic – porcelain/ceramic | 60% |
| D6250 | Pontic – resin with high noble metal | 60% |
| D6251 | Pontic – resin with predominantly base metal | 60% |
| D6252 | Pontic – resin with noble metal | 60% |
| D6253 | Provisional pontic | 60% |
| D6254 | Interim pontic | 60% |
| D6545 | Retainer – cast metal for resin bonded fixed prosthesis | 60% |
| D6548 | Retainer – porcelain/ceramic for resin bonded fixed prosthesis | 60% |
| D6600 | Inlay – porcelain/ceramic, two surfaces | 60% |
| D6601 | Inlay – porcelain/ceramic, three or more surfaces | 60% |
| D6602 | Inlay – cast high noble metal, two surfaces | 60% |
| D6603 | Inlay – cast high noble metal, three or more surfaces | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------------|--|----------------------------|
| D6604 | Inlay – cast predominantly base metal, two surfaces | 60% |
| D6605 | Inlay – cast predominantly base metal, three or more surfaces | 60% |
| D6606 | Inlay – cast noble metal, two surfaces | 60% |
| D6607 | Inlay – cast noble metal, three or more surfaces | 60% |
| D6608 | Onlay – porcelain/ceramic, two surfaces | 60% |
| D6609 | Onlay – porcelain/ceramic, three or more surfaces | 60% |
| D6610 | Onlay – cast high noble metal, two surfaces | 60% |
| D6611 | Onlay – cast high noble metal, three or more surfaces | 60% |
| D6612 | Onlay – cast predominantly base metal, two surfaces | 60% |
| D6613 | Onlay – cast predominantly base metal, three or more surfaces | 60% |
| D6614 | Onlay – cast noble metal, two surfaces | 60% |
| D6615 | Onlay – cast noble metal, three or more surfaces | 60% |
| D6624 | Inlay – titanium | 60% |
| D6634 | Onlay – titanium | 60% |
| D6710 | Crown – indirect resin based composite | 60% |
| D6720 | Crown – resin with high noble metal | 60% |
| D6721 | Crown – resin with predominantly base metal | 60% |
| D6722 | Crown – resin with noble metal | 60% |
| D6740 | Crown – porcelain/ceramic | 60% |
| D6750 | Crown – porcelain fused to high noble metal | 60% |
| D6751 | Crown – porcelain fused to predominantly base metal | 60% |
| D6752 | Crown – porcelain fused to noble metal | 60% |
| D6780 | Crown – ¾ cast high noble metal | 60% |
| D6781 | Crown – ¾ cast predominantly base metal | 60% |
| D6782 | Crown – ¾ cast noble metal | 60% |
| D6783 | Crown – ¾ porcelain/ceramic | 60% |
| D6790 | Crown – full cast high noble metal | 60% |
| D6791 | Crown – full cast predominantly base metal | 60% |
| D6792 | Crown – full cast noble metal | 60% |
| D6793 | Provisional retainer crown | 60% |
| D6794 | Crown – titanium | 60% |
| D6795 | Interim retainer crown | 60% |
| D6930 | Recement fixed partial denture | 60% |
| D6940 | Stress breaker | 60% |
| D6950 | Precision attachment | 60% |
| D6970 | Post and core in addition to fixed partial denture retainer, indirectly fabricated | 60% |
| D6972 | Prefabricated post and core in addition to fixed partial denture retainer | 60% |
| D6973 | Core build up for retainer, including any pins | 60% |
| D6976 | Each additional indirectly fabricated post – same tooth | 60% |
| D6977 | Each additional prefabricated post – same tooth | 60% |
| D6980 | Fixed partial denture repair, by report | 60% |

Oral Surgery

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------|---|---------------------|
| | <ul style="list-style-type: none"> 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 | 90% |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 90% |
| 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 | 90% |
| D7220 | Removal of impacted tooth – soft tissue | 90% |
| D7230 | Removal of impacted tooth – partially bony | 90% |
| D7240 | Removal of impacted tooth – completely bony | 90% |
| D7241 | Removal of impacted tooth – completely bony, with unusual surgical complications | 90% |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | 90% |
| D7251 | Coronectomy – intentional partial tooth removal | 90% |
| D7260 | Oroantral fistula closure | 60% |
| D7261 | Primary closure of a sinus perforation | 60% |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | 60% |
| D7280 | Surgical access of an unerupted tooth | 60% |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | 60% |
| 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 | 60% |
| D7287 | Exfoliative cytological sample collection | 60% |
| D7288 | Brush biopsy – transepithelial sample collection | 60% |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | 50% |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | 60% |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | 60% |
| D7320 | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | 60% |
| D7321 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | 60% |
| D7340 | Vestibuloplasty – ridge extension (secondary epithelialization) | 60% |
| D7350 | Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | 60% |
| D7450 | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm | 60% |
| D7451 | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | 60% |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 60% |
| D7472 | Removal of torus palatinus | 60% |
| D7473 | Removal of torus mandibularis | 60% |
| D7485 | Surgical reduction of osseous tuberosity | 60% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|------------------------------------|---|---------------------|
| D7510 | Incision and drainage of abscess – intraoral soft tissue | 60% |
| D7511 | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 60% |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | 60% |
| D7521 | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 60% |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone | 60% |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body | 60% |
| D7910 | Suture of recent small wounds up to 5 cm | 60% |
| D7950 | Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report | 60% |
| D7951 | Sinus augmentation with bone or bone substitutes | 60% |
| D7953 | Bone replacement graft for ridge preservation – per site | 60% |
| D7960 | Frenulectomy – also known as (frenectomy or frenotomy) – separate procedure not incidental to another procedure | 60% |
| D7963 | Frenuloplasty | 60% |
| D7970 | Excision of hyperplastic tissue – per arch | 60% |
| D7971 | Excision of pericoronal gingiva | 60% |
| D7972 | Surgical reduction of fibrous tuberosity | 60% |
| Orthodontics | | |
| | <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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. | 50% |
| Adjunctive General Services | | |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | 90% |
| D9120 | Fixed partial denture sectioning | 60% |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | 100% |

SCHEDULE OF BENEFITS (continued)

| Code | Service | Percentage We Cover |
|-------------|---|----------------------------|
| 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 | 60% |
| D9221 | Deep sedation/general anesthesia – each additional 15 minutes | 60% |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | 90% |
| D9241 | Intravenous conscious sedation/analgesia – first 30 minutes | 60% |
| D9242 | Intravenous conscious sedation/analgesia – each additional 15 minutes | 60% |
| D9248 | Non-intravenous conscious sedation | 90% |
| 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 | 90% |
| D9450 | Case presentation, detailed and extensive treatment planning | 100% |
| D9610 | Therapeutic parenteral drug, single administration | 90% |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | 90% |
| D9630 | Other drugs and/or medicaments, by report | 90% |
| D9910 | Application of desensitizing medicament | 90% |
| D9930 | Treatment of complication (post-surgical) – unusual circumstances, by report | 100% |
| D9940 | Occlusal guard, by report | 60% |
| D9942 | Repair and/or relines of occlusal guard | 60% |
| D9951 | Occlusal adjustment – limited | 60% |
| D9952 | Occlusal adjustment – complete | 60% |

Current Dental Terminology © American Dental Association

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 during. Interim prostheses are to be used for a period of at least two (2) months duration. These procedures are to be utilized 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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

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**。