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Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: SafeGuard Health Plans, Inc.
Type of Product Line: DHMO
Effective Date: Beginning on or after 10/18/2004

Name of Product: SG100
Plan Phone #: 800-880-1800
Plan Website: www.metlife.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE www.metlife.com OR CALL 800-880-1800.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	None
Orthodontia	None	None

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

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Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not Applicable	Not Applicable
Lifetime or Annual Maximum for Orthodontia	Not applicable - Exclusions apply	Not Applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package does not include a waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	$0	Not Covered	Additional Exclusions and limitations apply. Refer to your Schedule of Benefits for a complete list.
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	

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Cleaning	Preventive & Diagnostic	$0	Not Covered	Limited to 2 per year unless medically necessary.
Filling	Basic	$0	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not Covered	The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.
Root Canal	Basic	$200	Not Covered	Your cost for endodontic procedures does not include the cost of the final restoration.
Scaling and Root Planing	Basic	$25	Not Covered	
Ceramic Crown	Major	$225	Not Covered	• Replacement limit 1 every 5 years. • An additional charge will be applied for any procedure using noble or high noble metal. • There is a $75 Co-Payment per molar, for the use of porcelain.
Removable Partial Denture	Major	$150	Not Covered	• Relines are limited to 1 every 24 months. • Includes up to 3 adjustments within 6 months of delivery. • Replacement limit 1 every 5 years. • Replacements will be a benefit only if the existing denture is unsatisfactory and cannot be made satisfactory.
Erupted Tooth with Bone Removal	Major	$20	Not Covered	The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.
Orthodontia	Orthodontia	$1450	Not Covered	• Plan benefits cover 24 months of usual and customary orthodontic treatment. • Retreatment of orthodontic cases is excluded.

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Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable

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Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $65 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $225 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $65 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $225 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	• Full-mouth X-rays: Once every three (3) years, unless medically necessary. • Cleaning: Limited to 2 per year unless medically necessary.	Summary of what is not covered or subject to a limitation:		Summary of what is not covered or subject to a limitation:	• Replacement limit 1 every 5 years. • An additional charge will be applied for any procedure using noble or high noble metal. • $75 fee per crown unit above co-pay for porcelain on molars.

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**。

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SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan* SG100

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. SafeGuard is an affiliate of MetLife.

Specialty Care Information: During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your selected general dentist may refer you directly to a contracted SafeGuard specialty care provider for endodontics, oral surgery, orthodontics, periodontics, or pedodontics; no referral or preauthorization from SafeGuard is required.

* Prior authorization from SafeGuard is required for referrals to participating orthodontists and pediatric specialists. Your selected general dentist will submit all required documentation to SafeGuard and SafeGuard will advise you of the name, address and telephone number of a SafeGuard contracted orthodontist or pediatric specialist in your area.

Code	Service	Co-payment
	Diagnostic Treatment	
D0120	Periodic oral evaluation - established patient. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0171	Re-evaluation – post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient. This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.	$0
•	Office visit - per visit (including all fees for sterilization and/or infection control)	$5
	Radiographs/Diagnostic Imaging (X-rays)	
D0210	A radiographic survey of the whole mouth, usually consisting of 14-22 periapical	$0

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
	and posterior bitewing images intended to display the crowns and roots of all.	
D0220	Intraoral – periapical first radiographic image	$0
D0230	Intraoral – periapical each additional radiographic image	$0
D0240	Intraoral – occlusal radiographic image	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing – single radiographic image	$0
D0272	Bitewings – two radiographic images	$0
D0273	Bitewings – three radiographic images	$0
D0274	Bitewings – four radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
	Tests and Examinations	
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
	Preventive Services	
	Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.	
D1110	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.*	$0
D1120	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.*	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$5
D1510	Space maintainer – fixed, unilateral – per quadrant Excludes a distal shoe space maintainer	$30
D1516	Space maintainer – fixed – bilateral, maxillary	$30
D1517	Space maintainer – fixed – bilateral, mandibular	$30
D1520	Space maintainer – removable, unilateral – per quadrant	$30
D1526	Space maintainer – removable – bilateral, maxillary	$30
D1527	Space maintainer – removable – bilateral, mandibular	$30
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$5
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$5
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$5
D1556	Removal of fixed unilateral space maintainer – per quadrant	$5
D1557	Removal of fixed bilateral space maintainer – maxillary	$5
D1558	Removal of fixed bilateral space maintainer – mandibular	$5
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$65
D2392	Resin-based composite – two surfaces, posterior	$75
D2393	Resin-based composite – three surfaces, posterior	$80
D2394	Resin-based composite – four or more surfaces, posterior	$80
	Crowns	
	• *Replacement limit 1 every 5 years.* • *An additional charge will be applied for any procedure using noble or high noble metal.* • *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.* • *$75 fee per crown unit above co-pay for porcelain on molars.*	
D2510	Inlay – metallic – one surface	$100
D2520	Inlay – metallic – two surfaces	$100
D2530	Inlay – metallic – three or more surfaces	$100
D2543	Onlay – metallic – three surfaces	$100
D2544	Onlay – metallic – four or more surfaces	$100
D2740	Crown - porcelain/ceramic	$225
D2750	Crown – porcelain fused to high noble metal	$100
D2751	Crown – porcelain fused to predominantly base metal	$100
D2752	Crown – porcelain fused to noble metal	$100
D2753	Crown - porcelain fused to titanium and titanium alloys	$100
D2780	Crown – ¾ cast high noble metal	$100
D2781	Crown – ¾ cast predominantly base metal	$100
D2782	Crown – ¾ cast noble metal	$100
D2790	Crown – full cast high noble metal	$100
D2791	Crown – full cast predominantly base metal	$100
D2792	Crown – full cast noble metal	$100
D2794	Crown - titanium and titanium alloys	$100
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown – primary tooth	$0
D2931	Prefabricated stainless steel crown – permanent tooth	$0
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$15
D2951	Pin retention – per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$40
D2954	Prefabricated post and core in addition to crown	$40
D2955	Post removal	$10
	Endodontics	

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
	All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$5
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$10
D3310	Anterior (excluding final restoration)	$70
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$80
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$200
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3346	Retreatment of previous root canal therapy – anterior	$80
D3347	Retreatment of previous root canal therapy - premolar	$100
D3348	Retreatment of previous root canal therapy – molar	$210
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification – interim medication replacement	$65
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy – anterior	$180
D3421	Apicoectomy - premolar (first root)	$180
D3425	Apicoectomy – molar (first root)	$180
D3426	Apicoectomy (each additional root)	$180
D3430	Retrograde filling – per root	$180
D3450	Root amputation – per root	$95
D3920	Hemisection (including any root removal), not including root canal therapy	$90
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	$50
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	$38
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	$300
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland	$225

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
	flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	
D4249	Clinical crown lengthening – hard tissue	$125
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$300
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$225
D4270	Pedicle soft tissue graft procedure	$250
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$25
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$19
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	$25
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$60
D4910	Periodontal maintenance (2 in a 12 month period)	$25
	Removable Prosthodontics	
	• *Relines are limited to 1 every 24 months.*	
	• *Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$125
D5120	Complete denture – mandibular	$125
D5130	Immediate denture – maxillary	$125
D5140	Immediate denture – mandibular	$125
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$110
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$110
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$150
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$150
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5520	Replace missing or broken teeth – complete denture (each tooth)	$15
D5630	Repair or replace broken retentive clasping materials – per tooth	$15
D5640	Replace broken teeth – per tooth	$15
D5650	Add tooth to existing partial denture	$15
D5660	Add clasp to existing partial denture - per tooth	$15
D5710	Rebase complete maxillary denture	$50

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
D5711	Rebase complete mandibular denture	$50
D5720	Rebase maxillary partial denture	$50
D5721	Rebase mandibular partial denture	$50
D5730	Reline complete maxillary denture (chairside)	$40
D5731	Reline complete mandibular denture (chairside)	$40
D5740	Reline maxillary partial denture (chairside)	$40
D5741	Reline mandibular partial denture (chairside)	$40
D5750	Reline complete maxillary denture (laboratory)	$40
D5751	Reline complete mandibular denture (laboratory)	$40
D5760	Reline maxillary partial denture (laboratory)	$40
D5761	Reline mandibular partial denture (laboratory)	$40
D5820	Interim partial denture (maxillary)	$40
D5821	Interim partial denture (mandibular)	$40
D5850	Tissue conditioning, maxillary	$10
D5851	Tissue conditioning, mandibular	$10
	Crowns/Fixed Bridges - Per Unit	
	• *Replacement limit 1 every 5 years.*	
	• *An additional charge will be applied for any procedure using noble or high noble metal.*	
	• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*	
	• *$75 fee per crown unit above co-pay for porcelain on molars.*	
D6210	Pontic – cast high noble metal	$100
D6211	Pontic – cast predominantly base metal	$100
D6212	Pontic – cast noble metal	$100
D6214	Pontic – titanium and titanium alloys	$100
D6240	Pontic – porcelain fused to high noble metal	$100
D6241	Pontic – porcelain fused to predominantly base metal	$100
D6242	Pontic – porcelain fused to noble metal	$100
D6243	Pontic – porcelain fused to titanium and titanium alloys	$100
D6750	Retainer crown – porcelain fused to high noble metal	$100
D6751	Retainer crown – porcelain fused to predominantly base metal	$100
D6752	Retainer crown – porcelain fused to noble metal	$100
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$100
D6780	Retainer crown – ¾ cast high noble metal	$100
D6781	Retainer crown – ¾ cast predominantly base metal	$100
D6782	Retainer crown – ¾ cast noble metal	$100
D6784	Retainer crown – ¾ titanium and titanium alloys	$100
D6790	Retainer crown – full cast high noble metal	$100
D6791	Retainer crown – full cast predominantly base metal	$100
D6792	Retainer crown – full cast noble metal	$100
D6794	Retainer crown – titanium and titanium alloys	$100
D6930	Re-cement or re-bond fixed partial denture	$0
	Oral Surgery	
	• *Includes routine post operative visits/treatment.*	

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
	• *Surgical removal of impacted teeth not covered unless pathology (disease) exists.*	
	• *Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.*	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$20
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partially bony	$100
D7240	Removal of impacted tooth – completely bony	$125
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$130
D7250	Removal of residual tooth roots (cutting procedure)	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Exposure of an unerupted tooth	$175
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$0
D7286	Incisional biopsy of oral tissue – soft	$0
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$0
D7961	Buccal / labial frenectomy (frenulectomy)	$0
D7962	Lingual frenectomy (frenulectomy)	$0
D7963	Frenuloplasty	$0
D7971	Excision of pericoronal gingiva	$40
	Orthodontics	
	Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.	
D8020	Limited orthodontic treatment of the transitional dentition	$725
D8030	Limited orthodontic treatment of the adolescent dentition	$725
D8040	Limited orthodontic treatment of the adult dentition	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,450
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,450
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,450
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8698	Re-cement or re-bond fixed retainer – maxillary	$0
D8699	Re-cement or re-bond fixed retainer – maxillary	$0
•	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	$250
	Adjunctive General Services	
D9110	Palliative treatment of dental pain per visit: Treatment that relieves pain but is	$0

SCHEDULE OF BENEFITS (Continued)

Code	Service	Co-payment
	not curative; services provided do not have distinct procedure codes. This is typically reported on a “per-visit” basis for emergency treatment of dental pain.	
D9120	Fixed partial denture sectioning	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9310	Consultation – diagnostic service provided by dentist or physician other	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit – after regularly scheduled hours	$25
D9630	Drugs or medicaments dispensed in the office for home use	$15
D9951	Occlusal adjustment – limited	$0
D9952	Occlusal adjustment – complete	$0
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0

Dental Terminology Definitions

These definitions are designed to give you a “layman’s understanding” of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam:	A silver filling
Anterior:	Teeth that are in the front of the mouth
Bicuspid:	Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
Bridge:	A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
Crown:	A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.
Endodontics:	Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
Oral Surgery:	Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
Orthodontics:	Braces and other procedures to straighten the teeth.
Periodontics:	Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
Posterior:	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth:	The first set of teeth (“baby” teeth).
Prophylaxis:	Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics:	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant:	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite:	Tooth-colored (white) fillings

Exclusions and Limitations

Exclusions

1. Services performed by a general dentist or specialty care dentist, not contracted with SafeGuard, without prior approval by SafeGuard (except for out of area emergency services).
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
4. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist.
5. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
6. Orthognathic surgery.
7. General anesthesia or intravenous sedation.
8. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
9. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
10. Treatment of malignancies, cysts, or neoplasms.
11. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
12. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
13. Precision attachments.
14. 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.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Exclusions and Limitations

Limitations

1. Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.
2. An additional charge will be applied for any procedure using noble or high noble metal.
3. Relines are limited to one every twenty four (24) months.
4. Full-mouth X-rays: Once every three (3) years, unless medically necessary.
5. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.
6. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.
7. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
8. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
9. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.
10. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
11. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
12. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
13. Surgical removal of impacted teeth is not a covered benefit unless pathology (disease) exists.
14. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist in order for the co-payments listed in the Schedule of Benefits to apply.
2. 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 per-office-visit charge of $25 dollars.
3. The following are not included as orthodontic benefits:
   a). Repair or replacement of lost or broken appliances;
   b). Retreatment of orthodontic cases;
   c). Treatment in progress at inception of eligibility;
   d). Interceptive orthodontics;
   e). Changes in treatment necessitated by an accident;
   f). Treatment involving:
      1). Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
      2). Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      3). Treatment related to temporomandibular joint disorders;
      4). Lingually placed direct bonded appliances and arch wires (“invisible braces”); and
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

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**。