MetLife

SCHEDULE OF BENEFITS

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

DIRECT REFERRAL DENTAL PLAN SGX/SGXM 185-TX-HCR

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 and Limitations. SafeGuard is an affiliate of MetLife.

During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your SafeGuard selected general dentist may refer you directly to a contracted SafeGuard specialty care provider; no referral or pre-authorization from SafeGuard is required.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention.

Out-of-Pocket Maximums

Individual Out-of-Pocket Annual Maximum	
• In-Network	$375, for one child under age 19
• Out-of-Network	None
Family Out-of-Pocket Annual Maximum	
• In-Network	$750, for 2 or more children under age 19
• Out-of-Network	None

The Covered Person's out-of-pocket annual maximum includes the Covered Person's Co-Payments for Covered Services provided by the Selected General Dentist or Specialty Care Dentist. The out-of-pocket annual maximum does not include the Covered Person's Co-Payments for: (1) non-medically necessary Orthodontia, (2) services that are not Covered Services or (3) services that are in addition to the Essential Health Benefits as identified by the state of Texas.

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	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	$0	$0

*** – Service Not Covered**

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	findings are discussed with the patient. Report additional diagnostic procedures separately.		
D0140	Limited oral evaluation - problem focused	$0	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0	$0
D0150	Comprehensive oral evaluation - new or established patient	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	$0
D0171	Re-evaluation – post-operative office visit	$0	$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	$0
D0190	Screening of a patient	*	$0
D0191	Assessment of a patient	*	$0
●	Office visit - per visit (including all fees for sterilization and/or infection control)	$5	$5
	Radiographs/Diagnostic Imaging (X-rays)		
D0210	A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all.	$0	$0
D0220	Intraoral – periapical first radiographic image	$0	$0
D0230	Intraoral – periapical each additional radiographic image	$0	$0
D0240	Intraoral – occlusal radiographic image	$0	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0	$0
D0251	Extra-oral posterior dental radiographic image	$0	$0
D0270	Bitewing – single radiographic image	$0	$0
D0272	Bitewings – two radiographic images	$0	$0
D0273	Bitewings – three radiographic images	$0	$0
D0274	Bitewings – four radiographic images	$0	$0
D0277	Vertical bitewings – 7 to 8 radiographic images	$0	$0
D0330	Panoramic radiographic image	$0	$0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	See the Orthodontics section	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0	$0
D0364	Cone beam CT capture and interpretation with limited field of view -	*	$180

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	less than one whole jaw		
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	*	$180
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	*	$180
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	*	$180
D0372	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Comprehensive series of radiographic images.	$0	$0
D0373	Intraoral tomosynthesis- bitewing radiographic image	$0	$0
D0374	Intraoral tomosynthesis – periapical radiographic image	$0	$0
D0380	Cone beam CT image capture with limited field of view - less than one whole jaw	*	$180
D0381	Cone beam CT image capture with field of view of one full dental arch - mandible	*	$180
D0382	Cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	*	$180
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	*	$180
D0391	Interpretation of diagnostic image by a practitioner not association with capture of the image, including report	*	$0
	Tests and Examinations		
D0415	Collection of microorganisms for culture and sensitivity	$0	$0
D0425	Caries susceptibility tests	$0	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50	$50
D0460	Pulp vitality tests	$0	$0
D0470	Diagnostic casts	$0	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	*	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$0	$0
D0502	Other oral pathology procedures, by report	*	$0
	Preventive Services		

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
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	$0
●	Additional-adult prophylaxis (maximum of 2 additional per year)	$35	$35
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	$0
●	Additional-child prophylaxis (maximum of 2 additional per year)	$25	$25
D1206	Topical application of fluoride varnish	$0	$0
D1208	Topical application of fluoride – excluding varnish	$0	$0
D1310	Nutritional counseling for control of dental disease	$0	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0	$0
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant – per tooth	$0	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0	$0
D1353	Sealant repair - per tooth	*	$0
D1354	Application of caries arresting medicament – per tooth. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	$0	$0
D1355	Caries preventive medicament application – per tooth	$0	$0
D1510	Space maintainer – fixed, unilateral – per quadrant Excludes a distal shoe space maintainer.	$25	$25
D1516	Space maintainer – fixed – bilateral, maxillary	$25	$25
D1517	Space maintainer – fixed – bilateral, mandibular	$25	$25
D1520	Space maintainer – removable, unilateral – per quadrant	$35	$35
D1526	Space maintainer – removable – bilateral, maxillary	$35	$35
D1527	Space maintainer – removable – bilateral, mandibular	$35	$35
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$5	$5
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$5	$5
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$5	$5
D1556	Removal of fixed unilateral space maintainer – per quadrant	$5	$5
D1557	Removal of fixed bilateral space maintainer - maxillary	$5	$5
D1558	Removal of fixed bilateral space maintainer - mandibular	$5	$5
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant. Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliance, once the tooth had erupted.	$25	$25
	Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	$10	$10
D2150	Amalgam – two surfaces, primary or permanent	$15	$15

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D2160	Amalgam – three surfaces, primary or permanent	$18	$18
D2161	Amalgam – four or more surfaces, primary or permanent	$20	$20
D2330	Resin-based composite – one surface, anterior	$10	$10
D2331	Resin-based composite – two surfaces, anterior	$15	$15
D2332	Resin-based composite – three surfaces, anterior	$18	$18
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$20	$20
D2390	Resin-based composite crown, anterior	$30	$30
D2391	Resin-based composite – one surface, posterior	$30	$30
D2392	Resin-based composite – two surfaces, posterior	$45	$45
D2393	Resin-based composite – three surfaces, posterior	$65	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65	$65
	Crowns • *An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 co-payment per molar, for the use of porcelain.* • *Cases involving seven (7) or more crowns, implants and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to co-payment for each crown, implant or bridge unit.*		
D2510	Inlay – metallic – one surface	$165	$165
D2520	Inlay – metallic – two surfaces	$165	$165
D2530	Inlay – metallic – three or more surfaces	$165	$165
D2542	Onlay – metallic – two surfaces	$185	$185
D2543	Onlay – metallic – three surfaces	$185	$185
D2544	Onlay – metallic – four or more surfaces	$185	$185
D2610	Inlay – porcelain/ceramic – one surface	$185	$185
D2620	Inlay – porcelain/ceramic – two surfaces	$185	$185
D2630	Inlay – porcelain/ceramic – three or more surfaces	$185	$185
D2642	Onlay – porcelain/ceramic – two surfaces	$185	$185
D2643	Onlay – porcelain/ceramic – three surfaces	$185	$185
D2644	Onlay – porcelain/ceramic – four or more surfaces	$185	$185
D2650	Inlay – resin-based composite – one surface	$185	$185
D2651	Inlay – resin-based composite – two surfaces	$185	$185
D2652	Inlay – resin-based composite – three or more surfaces	$185	$185
D2662	Onlay – resin-based composite – two surfaces	$185	$185
D2663	Onlay – resin-based composite – three surfaces	$185	$185
D2664	Onlay – resin-based composite – four or more surfaces	$185	$185
D2710	Crown – resin-based composite (indirect)	$185	$185
D2712	Crown – ¾ resin-based composite (indirect)	$185	$185
D2720	Crown – resin with high noble metal	$185	$185
D2721	Crown – resin with predominantly base metal	$185	$185

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D2722	Crown – resin with noble metal	$185	$185
D2740	Crown - porcelain/ceramic	$225	$225
D2750	Crown – porcelain fused to high noble metal	$185	$185
D2751	Crown – porcelain fused to predominantly base metal	$185	$185
D2752	Crown – porcelain fused to noble metal	$185	$185
D2753	Crown - porcelain fused to titanium and titanium alloys	$185	$185
D2780	Crown – ¾ cast high noble metal	$185	$185
D2781	Crown – ¾ cast predominantly base metal	$185	$185
D2782	Crown – ¾ cast noble metal	$185	$185
D2783	Crown – ¾ porcelain/ceramic	$185	$185
D2790	Crown – full cast high noble metal	$185	$185
D2791	Crown – full cast predominantly base metal	$185	$185
D2792	Crown – full cast noble metal	$185	$185
D2794	Crown - titanium and titanium alloys	$185	$185
D2799	Interim crown – further treatment or completion of diagnosis necessary prior to final impression. Further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary crown for a routine prosthetic restoration.	$0	$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0	$0
D2920	Re-cement or re-bond crown	$0	$0
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$113	$113
D2930	Prefabricated stainless steel crown – primary tooth	$25	$25
D2931	Prefabricated stainless steel crown – permanent tooth	$25	$25
D2932	Prefabricated resin crown	$35	$35
D2933	Prefabricated stainless steel crown with resin window	$35	$35
D2940	Protective restoration	$0	$0
D2941	Interim therapeutic restoration - primary dentition	$0	$0
D2950	Core buildup, including any pins when required	$50	$50
D2951	Pin retention – per tooth, in addition to restoration	$10	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50	$50
D2953	Each additional indirectly fabricated post – same tooth	$50	$50
D2954	Prefabricated post and core in addition to crown	$30	$30
D2955	Post removal	$10	$10
D2957	Each additional prefabricated post – same tooth	$30	$30
D2960	Labial veneer (resin laminate) – chairside	$250	$250
D2961	Labial veneer (resin laminate) – laboratory	$300	$300
D2962	Labial veneer (porcelain laminate) – laboratory	$350	$350
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate a crown procedure documented with its own code.	$50	$50

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D2980	Crown repair necessitated by restorative material failure	$0	$0
D2981	Inlay repair necessitated by restorative material failure	$0	$0
D2982	Onlay repair necessitated by restorative material failure	$0	$0
D2983	Veneer repair necessitated by restorative material failure	$0	$0
D2990	Resin infiltration of incipient smooth surface lesions	*	$0
	Endodontics		
	All procedures exclude final restoration.		
D3110	Pulp cap – direct (excluding final restoration)	$0	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$10	$10
D3221	Pulpal debridement, primary and permanent teeth	$45	$45
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$10	$10
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$30	$30
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$35	$35
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$80	$80
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$115	$115
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$200	$200
D3331	Treatment of root canal obstruction; non-surgical access	$85	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70	$70
D3333	Internal root repair of perforation defects: Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by same provider.	$85	$85
D3346	Retreatment of previous root canal therapy – anterior	$135	$135
D3347	Retreatment of previous root canal therapy - premolar	$175	$175
D3348	Retreatment of previous root canal therapy – molar	$275	$275
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$65	$65
D3352	Apexification/recalcification – interim medication replacement	$65	$65
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$65	$65
D3355	Pulpal regeneration - initial visit	*	$80
D3356	Pulpal regeneration - interim medication replacement	*	$40
D3357	Pulpal regeneration - completion of treatment	*	$80
D3410	Apicoectomy – anterior	$95	$95
D3421	Apicoectomy - premolar (first root)	$95	$95
D3425	Apicoectomy – molar (first root)	$95	$95

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D3426	Apicoectomy (each additional root)	$60	$60
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	*	$180
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	*	$95
D3430	Retrograde filling – per root	$40	$40
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	*	$95
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	*	$215
D3450	Root amputation – per root	$95	$95
D3460	Endodontic endosseous implant	*	$555
D3471	Surgical repair of root resorption –anterior	$72	$72
D3472	Surgical repair of root resorption – premolar	$72	$72
D3473	Surgical repair of root resorption – molar	$72	$72
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	*	$53
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	*	$53
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	*	$53
D3910	Surgical procedure for isolation of tooth with rubber dam	$19	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$90	$90
D3921	Decoronation or submergence of an erupted tooth	*	$40
D3950	Canal preparation and fitting of preformed dowel or post	$15	$15
	Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$90	$90
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$68	$68
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	*	$30
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	$150	$150

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	concurrent to D4240 and should be reported separately using their own unique codes.		
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 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.	$113	$113
D4245	Apically positioned flap	$165	$165
D4249	Clinical crown lengthening – hard tissue	$120	$120
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$295	$295
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$210	$210
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$180	$180
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$95	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site. Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.	$95	$95
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	$215	$215
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects	$255	$255

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	around natural teeth.		
D4268	Surgical revision procedure, per tooth	*	$0
D4270	Pedicle soft tissue graft procedure	$245	$245
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70	$70
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380	$380
D4276	Combined connective tissue and pedicle graft, per tooth. Advanced gingival recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome.	*	$75
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$245	$245
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$123	$123
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$38	$38
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$190	$190
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	$95	$95
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	$85	$85
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$40	$40
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$0	$0
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	$40	$40
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$60	$60
D4910	Periodontal maintenance	$30	$30
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	*	$0
●	Additional periodontal maintenance procedures (beyond 2 per 12 months)	$55	$55
●	Periodontal charting for planning treatment of periodontal disease	$0	$0
●	Periodontal hygiene instruction	$0	$0
	Removable Prosthodontics		

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	Includes up to 3 adjustments within 6 months of delivery.		
D5110	Complete denture – maxillary	$210	$210
D5120	Complete denture – mandibular	$210	$210
D5130	Immediate denture – maxillary	$225	$225
D5140	Immediate denture – mandibular	$225	$225
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$240	$240
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$240	$240
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$260	$260
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$260	$260
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	$240	$240
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	$240	$240
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	$260	$260
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	$260	$260
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$365	$365
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$365	$365
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth	$240	$240
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth	$240	$240
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$250	$250
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$250	$250
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	$125	$125
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$125	$125
D5410	Adjust complete denture – maxillary	$0	$0

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D5411	Adjust complete denture – mandibular	$0	$0
D5421	Adjust partial denture – maxillary	$0	$0
D5422	Adjust partial denture – mandibular	$0	$0
D5511	Repair broken complete denture base, mandibular	$30	$30
D5512	Repair broken complete denture base, maxillary	$30	$30
D5520	Replace missing or broken teeth – complete denture (each tooth)	$30	$30
D5611	Repair resin partial denture base, mandibular	$30	$30
D5612	Repair resin partial denture base, maxillary	$30	$30
D5621	Repair cast partial framework, mandibular	$30	$30
D5622	Repair cast partial framework, maxillary	$30	$30
D5630	Repair or replace broken retentive clasping materials – per tooth	$35	$35
D5640	Replace broken teeth – per tooth	$30	$30
D5650	Add tooth to existing partial denture	$30	$30
D5660	Add clasp to existing partial denture - per tooth	$35	$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165	$165
D5710	Rebase complete maxillary denture	$60	$60
D5711	Rebase complete mandibular denture	$60	$60
D5720	Rebase maxillary partial denture	$60	$60
D5721	Rebase mandibular partial denture	$60	$60
D5725	Rebase hybrid prosthesis	$60	$60
D5730	Reline complete maxillary denture (chairside)	$35	$35
D5731	Reline complete mandibular denture (chairside)	$35	$35
D5740	Reline maxillary partial denture (chairside)	$35	$35
D5741	Reline mandibular partial denture (chairside)	$35	$35
D5750	Reline complete maxillary denture (laboratory)	$60	$60
D5751	Reline complete mandibular denture (laboratory)	$60	$60
D5760	Reline maxillary partial denture (laboratory)	$60	$60
D5761	Reline mandibular partial denture (laboratory)	$60	$60
D5765	Soft liner for complete or partial removable denture – indirect	$60	$60
D5810	Interim complete denture (maxillary)	$230	$230
D5811	Interim complete denture (mandibular)	$230	$230
D5820	Interim partial denture (maxillary)	$60	$60
D5821	Interim partial denture (mandibular)	$60	$60
D5850	Tissue conditioning, maxillary	$10	$10
D5851	Tissue conditioning, mandibular	$10	$10
D5862	Precision attachment, by report. Each pair of components is one precision attachment. Describe the type of attachment used.	$160	$160
D5876	Add metal substructure to acrylic full denture (per arch)	$53	$53
	Crowns/Fixed Bridges/Implants - Per Unit		
	• *An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a*		

*** – Service Not Covered**

**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
	$75 co-payment per molar, for the use of porcelain.		
	• *Cases involving seven (7) or more crowns, implants and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to co-payment for each crown, implant or bridge unit.*		
D6010	Surgical placement of implant body: endosteal implant	*	$1,005
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	*	$770
D6013	Surgical placement of mini implant	*	$1,005
D6040	Surgical placement: eposteal implant	*	$1,860
D6050	Surgical placement: transosteal implant	*	$1,170
D6051	Interim implant abutment placement. A healing cap is not an interim abutment.	*	$123
D6055	Connecting bar - implant supported or abutment supported	*	$345
D6056	Prefabricated abutment- includes modification and placement	*	$245
D6057	Custom fabricated abutment- includes placement	*	$335
D6058	Abutment supported porcelain/ceramic crown	*	$685
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	*	$660
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	*	$640
D6061	Abutment supported porcelain fused to metal crown (noble metal)	*	$645
D6062	Abutment supported cast metal crown (high noble metal)	*	$655
D6063	Abutment supported cast metal crown (predominantly base metal)	*	$640
D6064	Abutment supported cast metal crown (noble metal)	*	$720
D6065	Implant supported porcelain/ceramic crown	*	$725
D6066	Implant supported crown - porcelain fused to high noble alloys. A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.	*	$700
D6067	Implant supported crown - high noble alloys. A single metal crown restoration that is retained, supported and stabilized by an implant.	*	$725
D6068	Abutment supported retainer for porcelain/ceramic FPD	*	$680
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	*	$680
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	*	$595
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	*	$635
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	*	$625
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	*	$445
D6074	Abutment supported retainer for cast metal FPD (noble metal)	*	$640
D6075	Implant supported retainer for ceramic FPD	*	$720

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys. A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.	*	$700
D6077	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant.	*	$510
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	*	$55
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	*	$20
D6082	Implant supported crown – porcelain fused to predominantly base alloys	*	$640
D6083	Implant supported crown – porcelain fused to noble alloys	*	$645
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	*	$650
D6086	Implant supported crown – predominantly base alloys	*	$640
D6087	Implant supported crown – noble alloys	*	$720
D6088	Implant supported crown – titanium and titanium alloys	*	$650
D6090	Repair implant supported prosthesis, by report	*	$190
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	*	$170
D6092	Re-cement or re-bond implant/abutment supported crown	*	$50
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	*	$70
D6094	Abutment supported crown - titanium and titanium alloys. A single crown restoration that is retained, supported and stabilized by an abutment on an implant.	*	$650
D6095	Repair implant abutment, by report	*	$140
D6096	Remove broken implant retaining screw	*	$24
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	*	$700
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	*	$595
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	*	$635
D6100	Surgical removal of implant body	*	$240
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	*	$39
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	*	$86
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	*	$100

*** – Service Not Covered**
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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D6104	Bone graft at time of implant placement	*	$100
D6105	Removal of implant body not requiring bone removal nor flap elevation	*	$240
D6106	Guided tissue regeneration – resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	$215	$215
D6107	Guided tissue regeneration – non-resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	$255	$255
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	*	$995
D6111	Implant/abutment supported removable denture for edentulous arch-mandibular	*	$995
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	*	$945
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	*	$945
D6114	Implant/abutment supported fixed denture for edentulous arch-maxillary	*	$2,380
D6115	Implant/abutment supported fixed denture for edentulous arch-mandibular	*	$2,380
D6116	Implant/abutment supported fixed denture for partially edentulous arch-maxillary	*	$1,410
D6117	Implant/abutment supported fixed denture for partially edentulous arch-mandibular	*	$1,410
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	*	$520
D6121	Implant supported retainer for metal FPD – predominantly base alloys	*	$445
D6122	Implant supported retainer for metal FPD – predominantly base alloys	*	$640
D6123	Implant supported retainer for metal FPD – noble alloys	*	$520
D6190	Radiographic/surgical implant index, by report	*	$130
D6191	Semi-precision abutment – placement	*	$335
D6192	Semi-precision attachment – placement	*	$252
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys. A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.	*	$520
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	*	$510
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	$30	$30

*** – Service Not Covered**

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D6205	Recement implant/abutment supported crown	*	$310
D6210	Pontic – cast high noble metal	$185	$185
D6211	Pontic – cast predominantly base metal	$185	$185
D6212	Pontic – cast noble metal	$185	$185
D6214	Pontic – titanium and titanium alloys	$185	$185
D6240	Pontic – porcelain fused to high noble metal	$185	$185
D6241	Pontic – porcelain fused to predominantly base metal	$185	$185
D6242	Pontic – porcelain fused to noble metal	$185	$185
D6243	Pontic – porcelain fused to titanium and titanium alloys	$185	$185
D6245	Pontic – porcelain/ceramic	$205	$205
D6250	Pontic – resin with high noble metal	$185	$185
D6251	Pontic – resin with predominantly base metal	$185	$185
D6252	Pontic – resin with noble metal	$185	$185
D6253	Further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary pontic for a routine prosthetic restoration.	$0	$0
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$150	$140
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	*	$140
D6549	Resin retainer-for resin bonded fixed prosthesis	*	$105
D6600	Retainer inlay – porcelain/ceramic, two surfaces	$185	$185
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$185	$185
D6602	Retainer inlay – cast high noble metal, two surfaces	$185	$185
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$185	$185
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$185	$185
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$185	$185
D6606	Retainer inlay – cast noble metal, two surfaces	$185	$185
D6607	Retainer inlay – cast noble metal, three or more surfaces	$185	$185
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$185	$185
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$185	$185
D6610	Retainer onlay – cast high noble metal, two surfaces	$185	$185
D6611	Retainer onlay – cast high noble metal, three or more surfaces	$185	$185
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$185	$185
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$185	$185
D6614	Retainer onlay – cast noble metal, two surfaces	$185	$185
D6615	Retainer onlay – cast noble metal, three or more surfaces	$185	$185
D6624	Retainer inlay – titanium	*	$335
D6634	Retainer onlay – titanium	*	$335
D6710	Retainer crown – indirect resin based composite	$185	$185
D6720	Retainer crown – resin with high noble metal	$185	$185
D6721	Retainer crown – resin with predominantly base metal	$185	$185

*** – Service Not Covered**
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Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D6722	Retainer crown – resin with noble metal	$185	$185
D6740	Retainer crown – porcelain/ceramic	$185	$185
D6750	Retainer crown – porcelain fused to high noble metal	$185	$185
D6751	Retainer crown – porcelain fused to predominantly base metal	$185	$185
D6752	Retainer crown – porcelain fused to noble metal	$185	$185
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$185	$185
D6780	Retainer crown – ¾ cast high noble metal	$185	$185
D6781	Retainer crown – ¾ cast predominantly base metal	$185	$185
D6782	Retainer crown – ¾ cast noble metal	$185	$185
D6783	Retainer crown – ¾ porcelain/ceramic	$185	$185
D6784	Retainer crown – ¾ titanium and titanium alloys	$185	$185
D6790	Retainer crown – full cast high noble metal	$185	$185
D6791	Retainer crown – full cast predominantly base metal	$185	$185
D6792	Retainer crown – full cast noble metal	$185	$185
D6793	Interim pontic. Further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary retainer crown for a routine prosthetic restoration.	*	$100
D6794	Retainer crown – titanium and titanium alloys	$185	$185
D6930	Re-cement or re-bond fixed partial denture	$0	$0
D6940	Stress breaker	$110	$110
D6950	Precision attachment. A pair of components constitutes one precision attachment, that is separate from the prosthesis.	$195	$195
D6980	Fixed partial denture repair necessitated by restorative material failure	$45	$45
	Oral Surgery ● *Includes routine post operative visits/treatment.* ● *The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.*		
D7111	Extraction, coronal remnants – primary tooth	$5	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$30	$30
D7220	Removal of impacted tooth – soft tissue	$45	$45
D7230	Removal of impacted tooth – partially bony	$65	$65
D7240	Removal of impacted tooth – completely bony	$80	$80
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$100	$100
D7250	Removal of residual tooth roots (cutting procedure)	$40	$40
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only: Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire tooth is removed.	$80	$80
D7260	Oroantral fistula closure	*	$270
D7261	Primary closure of a sinus perforation	*	$275

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50	$50
D7280	Exposure of an unerupted tooth	$85	$85
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90	$90
D7283	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	$90	$90
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$0	$0
D7286	Incisional biopsy of oral tissue – soft	$0	$0
D7287	Exfoliative cytological sample collection	$50	$50
D7288	Brush biopsy – transepithelial sample collection	$50	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	*	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$35	$35
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$10	$10
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40	$40
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$20	$20
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	*	$370
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	*	$990
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	*	$130
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	*	$335
D7471	Removal of lateral exostosis (maxilla or mandible)	$80	$80
D7472	Removal of torus palatinus	$60	$60
D7473	Removal of torus mandibularis	$60	$60
D7485	Reduction of osseous tuberosity	$60	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$30	$30
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$30	$30
D7520	Incision and drainage of abscess – extraoral soft tissue	$30	$30
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$30	$30
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	*	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	*	$505
D7910	Suture of recent small wounds up to 5 cm	$25	$25
D7921	Collection and application of autologous blood concentrate product	*	$95
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	*	$600

*** – Service Not Covered**

**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	*	$825
D7952	Sinus augmentation via a vertical approach	*	$825
D7953	Bone replacement graft for ridge preservation - per site	*	$100
D7961	Buccal / labial frenectomy (frenulectomy)	$40	$40
D7962	Lingual frenectomy (frenulectomy)	$40	$40
D7963	Frenuloplasty	$40	$40
D7970	Excision of hyperplastic tissue – per arch	$55	$55
D7971	Excision of pericoronal gingiva	$35	$35
D7972	Surgical reduction of fibrous tuberosity	*	$125
	Orthodontics ● *Both medically necessary and non-medically necessary Orthodontia is a Covered Service. Co-Payments made toward medically necessary Orthodontia are included in the Out-of-Pocket maximum for children under age 19.* ● *For orthodontia services, We strongly recommend that you get a pretreatment estimate of proposed orthodontic services and then discuss that estimate with your SafeGuard selected general dentist or specialty care dentist before the services are delivered. Even though pretreatment estimates are not guarantees of benefits, obtaining a pretreatment estimate is an important part of making a well-informed decision about orthodontic services, including what your plan may or may not cover under the Essential Health Benefit requirements. Please contact our Customer Service at (800) 880-1800 to request a pretreatment estimate.* ● *Benefits cover 24 months of usual & customary orthodontic treatment and an additional 24 months of retention.* ● *Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.*		
D8010	Limited orthodontic treatment of the primary dentition	$725	$725
D8020	Limited orthodontic treatment of the transitional dentition	$725	$725
D8030	Limited orthodontic treatment of the adolescent dentition	$725	$725
D8040	Limited orthodontic treatment of the adult dentition	$725	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,695	$1,695
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,695	$1,695
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,695	$1,695
D8210	Removable appliance therapy	25% Discount	$300
D8220	Fixed appliance therapy	25% Discount	$300
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0	$0
D8670	Periodic orthodontic treatment visit Periodic orthodontic treatment visit (as part of contract)	$0	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250	$250

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D8681	Removable orthodontic retainer adjustment	$0	$0
D8698	Re-cement or re-bond fixed retainer – maxillary	$0	$0
D8699	Re-cement or re-bond fixed retainer – mandibular	$0	$0
D8701	Repair of fixed retainer, includes reattachment – maxillary	*	$0
D8702	Repair of fixed retainer, includes reattachment – mandibular	*	$0
●	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250	$250
●	Ortho visits beyond 24 months of active treatment or retention	$25 per visit	$25 per visit
	Adjunctive General Services		
D9110	Palliative treatment of dental pain per visit: Treatment that relieves pain but is 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.	$0	$0
D9120	Fixed partial denture sectioning	$0	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0	$0
D9211	Regional block anesthesia	$0	$0
D9212	Trigeminal division block anesthesia	$0	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	*	$60
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	*	$60
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	$15
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	*	$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	*	$60
D9248	Non-intravenous conscious sedation	$15	$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	$0
D9311	Consultation with a medical health care professional	$0	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0	$0
D9440	Office visit – after regularly scheduled hours	$30	$30
D9450	Case presentation, subsequent to detailed and extensive treatment planning.	$0	$0
D9610	Therapeutic parenteral drug, single administration	$15	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$0	$0
D9613	Infiltration of sustained release therapeutic drug, per quadrant. Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control. Not for local anesthesia purposes.	$15	$15

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment for Covered Persons Other than Children Under age 19	Co-payment for Children Under Age 19
D9630	Drugs or medicaments dispensed in the office for home use	$15	$15
D9910	Application of desensitizing medicament	$15	$15
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	*	$0
D9932	Cleaning and inspection of removable complete denture, maxillary	*	$55
D9933	Cleaning and inspection of removable complete denture, mandibular	*	$55
D9934	Cleaning and inspection of removable partial denture, maxillary	*	$55
D9935	Cleaning and inspection of removable partial denture, mandibular	*	$55
D9942	Repair and/or reline of occlusal guard	$40	$40
D9943	Occlusal guard adjustment	$10	$10
D9944	Occlusal guard – hard appliance, full arch	$85	$85
D9945	Occlusal guard – soft appliance, full arch	$85	$85
D9946	Occlusal guard – hard appliance, partial arch	$64	$64
D9951	Occlusal adjustment – limited	$15	$15
D9952	Occlusal adjustment – complete	$50	$50
D9972	External bleaching – per arch – performed in office	$125	$125**
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0	$0

*** – Service Not Covered**
**** – Your Co-payment for this service is not included in the Out-of-Pocket Annual Maximum**

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

FOR COVERED PERSONS OTHER THAN CHILDREN UNDER AGE 19:

General

1. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.

2. Sealants and/or preventive resin restorations: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble, or titanium metal.

2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.

3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to the specified co-payment for each crown/bridge unit.

4. There is a $75 co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

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.

Prosthodontics

1. Relines 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 functioning tooth. 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 SafeGuard selected general dentist.

3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

4. 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.

Endodontics

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.

Orthodontics

1. If You or Your Dependent requires 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 terminates 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 Co-Payments 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. If You or Your Dependent started orthodontic treatment before Your coverage for Yourself or that Dependent started under this group contract, Continuing Orthodontic treatment is available under this group contract for You or Your Dependent under any of the following circumstances:

   a. You were covered under the terms of a dental plan provided by SafeGuard and, due to an acquisition, are now covered under the terms of this group contract;

   b. You were covered under the terms of a dental plan provided by a carrier other than SafeGuard and are now covered under the terms of this group contract because the Contractholder subsequently contracts with SafeGuard;

   c. You become eligible for DHMO benefits under the terms of this group contract because of Your status as a new employee; or

   d. You were covered under the terms of a dental plan and received orthodontic services which were not covered because that dental plan did not offer orthodontic coverage.

   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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

Continuing Orthodontic treatment will be available if You enroll within 30 days of the date You become eligible for benefits under the terms of this group contract.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

FOR CHILDREN UNDER AGE 19:

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 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 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. Two (2) additional cleanings (routine and periodontal) are available at the Co-Payment listed in 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.

Restorative Treatment, Crowns, Bridges, Fixed Bridges

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble, or titanium metal.

2. Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional $125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, implant or Bridge unit.

3. There is a $75 Co-Payment per molar, for the use of porcelain.

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. 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.

7. 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.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) months.

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

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

4. 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.

Implants

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:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth.

Endodontics

1. The Co-Payments listed for Endodontic procedures do 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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

3. 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 Us.

Orthodontics

1. If Your Dependent requires 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 Your Dependent terminates 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 Co-Payments 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. If You or Your Dependent started orthodontic treatment before Your coverage for Yourself or that Dependent started under this group contract, Continuing Orthodontic treatment is available under this group contract for You or Your Dependent under any of the following circumstances:

   a. You were covered under the terms of a dental plan provided by SafeGuard and, due to an acquisition, are now covered under the terms of this group contract;

   b. You were covered under the terms of a dental plan provided by a carrier other than SafeGuard and are now covered under the terms of this group contract because the Contractholder subsequently contracts with SafeGuard;

   c. You become eligible for DHMO benefits under the terms of this group contract because of Your status as a new employee; or

   d. You were covered under the terms of a dental plan and received orthodontic services which were not covered because that dental plan did not offer orthodontic coverage.

   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.

   Continuing Orthodontic treatment will be available if You enroll within 30 days of the date You become eligible for benefits under the terms of this group contract.

DENTAL BENEFITS: EXCLUSIONS

FOR COVERED PERSONS OTHER THAN CHILDREN UNDER AGE 19:

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are not covered.

2. Services performed by any dentist not contracted with SafeGuard, without prior approval by SafeGuard (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.

3. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, 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 the member's dental health, as determined by the SafeGuard selected general dentist.

5. Orthognathic surgery.

6. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications, except for palliative care for an Emergency Dental Condition.

7. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.

8. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.

9. Procedures, appliances, or restorations whose primary 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 specifically listed as a covered benefit on this Plan's Schedule of Benefits.

10. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.

11. 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.

12. Dental services required while serving in the Armed Forces of any country or international authority.

13. Dental services considered Experimental or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.

14. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

DENTAL BENEFITS: EXCLUSIONS

15. The following are not included as Orthodontic benefits:

    A. Repair or replacement of lost or broken appliances;
    B. Retreatment of Orthodontic cases;
    C. Treatment involving:
        i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
        ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
        iii. Treatment related to temporomandibular joint disorders;
        iv. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
    D. Invisalign services are excluded.

DENTAL BENEFITS: EXCLUSIONS (continued)

FOR CHILDREN UNDER AGE 19:

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. Any service which is not Dentally Necessary and/or medically necessary.

4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving 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, except for palliative care for an Emergency Dental Condition. General anesthesia or IV sedation is not covered for any reason if rendered in an outpatient 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 or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.

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

DENTAL BENEFITS: EXCLUSIONS (continued)

14. The following are not included as Orthodontic benefits:

    A. Repair or replacement of lost or broken appliances;
    B. Retreatment of Orthodontic cases;
    C. Treatment involving:
        i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
        ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
        iii. Treatment related to temporomandibular joint disorders;
        iv. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
    D. Invisalign services are excluded.