



SCHEDULE OF BENEFITS

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

Individual Plan Self Referral Dental Plan

TakeAlong Dental HMO/Managed Care 350

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

There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations; please review them before your first dental appointment. It is important to discuss all recommended procedures with your provider prior to treatment.

The following co-payments apply only when services are performed by your or your dependents selected SafeGuard general dentist. If you choose to receive services from a SafeGuard contracted specialty care provider (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 75% of that provider's fee for those services.

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

	Service	Your and Your Dependent's Co-Payment
	• Office visit - per visit (including all fees for sterilization and/or infection control)	\$10
Code	Service	Your and Your Dependent's Co-Payment
Diagnostic Treatment		
D0120	Periodic oral evaluation - established patient	\$0
D0140	Limited oral evaluation - problem focused	\$5
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

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0
D0171	Re-evaluation - post-operative office visit	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	\$0
D0190	Screening of a patient	\$0
D0191	Assessment of a patient	\$0
Radiographs / Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series of radiographic images	\$0
D0220	Intraoral – periapical first radiographic image	\$0
D0230	Intraoral – periapical each additional radiographic image	\$0
D0240	Intraoral – occlusal radiographic image	\$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$0
D0251	Extra-oral posterior dental radiographic image	\$0
D0270	Bitewing – single radiographic image	\$0
D0272	Bitewings – two radiographic images	\$0
D0273	Bitewings – three radiographic images	\$0
D0274	Bitewings – four radiographic images	\$0
D0277	Vertical bitewings – 7 to 8 radiographic images	\$0
D0330	Panoramic radiographic image	\$0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	75% of UCR
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$0
Tests and Examinations		
D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$50
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$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
D0480	Accession of exfoliative cytologic smears, microscopic examination,	\$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	preparation and transmission of written report	
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	\$0
D0502	Other oral pathology procedures, by report	\$0
Preventive Services		
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.	\$20
	• Additional-adult prophylaxis (maximum of 2 additional per year)	\$45
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.	\$20
	• Additional-child prophylaxis (maximum of 2 additional per year)	\$35
D1206	Topical application of fluoride varnish	\$0
D1208	Topical application of fluoride – excluding varnish	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
	• Includes periodontal hygiene instruction	
D1351	Sealant – per tooth	\$25
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	\$25
D1353	Sealant repair - per tooth	\$5
D1354	Interim caries arresting medicament application – per tooth	\$13
D1355	Caries preventive medicament application – per tooth	\$13
D1516	Space maintainer – fixed – bilateral, maxillary	\$70
D1517	Space maintainer – fixed – bilateral, mandibular	\$70
D1520	Space maintainer – removable, unilateral – per quadrant	\$80
D1526	Space maintainer – removable – bilateral, maxillary	\$80
D1527	Space maintainer – removable – bilateral, mandibular	\$80
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	\$20
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	\$20
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	\$20
D1556	Removal of fixed unilateral space maintainer – per quadrant	\$20
D1557	Removal of fixed bilateral space maintainer - maxillary	\$20
D1558	Removal of fixed bilateral space maintainer - mandibular	\$20
Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	\$15
D2150	Amalgam – two surfaces, primary or permanent	\$23
D2160	Amalgam – three surfaces, primary or permanent	\$26

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D2161	Amalgam – four or more surfaces, primary or permanent	\$28
D2330	Resin-based composite – one surface, anterior	\$25
D2331	Resin-based composite – two surfaces, anterior	\$35
D2332	Resin-based composite – three surfaces, anterior	\$50
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$70
D2390	Resin-based composite crown, anterior	\$60
D2391	Resin-based composite – one surface, posterior	\$70
D2392	Resin-based composite – two surfaces, posterior	\$80
D2393	Resin-based composite – three surfaces, posterior	\$110
D2394	Resin-based composite – four or more surfaces, posterior	\$125
Crowns		
	<ul style="list-style-type: none"> • 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 the specified Co-payment for each Crown, implant or Bridge unit. 	
D2510	Inlay – metallic – one surface	\$325
D2520	Inlay – metallic – two surfaces	\$325
D2530	Inlay – metallic – three or more surfaces	\$325
D2542	Onlay – metallic – two surfaces	\$325
D2543	Onlay – metallic – three surfaces	\$325
D2544	Onlay – metallic – four or more surfaces	\$325
D2610	Inlay – porcelain/ceramic – one surface	\$325
D2620	Inlay – porcelain/ceramic – two surfaces	\$325
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$325
D2642	Onlay – porcelain/ceramic – two surfaces	\$325
D2643	Onlay – porcelain/ceramic – three surfaces	\$325
D2644	Onlay – porcelain/ceramic – four or more surfaces	\$325
D2650	Inlay – resin-based composite – one surface	\$325
D2651	Inlay – resin-based composite – two surfaces	\$325
D2652	Inlay – resin-based composite – three or more surfaces	\$325
D2662	Onlay – resin-based composite – two surfaces	\$325
D2663	Onlay – resin-based composite – three surfaces	\$325
D2664	Onlay – resin-based composite – four or more surfaces	\$325
D2710	Crown – resin-based composite (indirect)	\$325
D2712	Crown – ¾ resin-based composite (indirect)	\$325
D2720	Crown – resin with high noble metal	\$325

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D2721	Crown – resin with predominantly base metal	\$325
D2722	Crown – resin with noble metal	\$325
D2740	Crown - porcelain/ceramic	\$350
D2750	Crown – porcelain fused to high noble metal	\$350
D2751	Crown – porcelain fused to predominantly base metal	\$350
D2752	Crown – porcelain fused to noble metal	\$350
D2753	Crown - porcelain fused to titanium and titanium alloys	\$350
D2780	Crown – ¾ cast high noble metal	\$350
D2781	Crown – ¾ cast predominantly base metal	\$350
D2782	Crown – ¾ cast noble metal	\$350
D2783	Crown – ¾ porcelain/ceramic	\$350
D2790	Crown – full cast high noble metal	\$350
D2791	Crown – full cast predominantly base metal	\$350
D2792	Crown – full cast noble metal	\$350
D2794	Crown - titanium and titanium alloys	\$350
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	\$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$15
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$15
D2920	Re-cement or re-bond crown	\$15
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	\$175
D2930	Prefabricated stainless steel crown – primary tooth	\$25
D2931	Prefabricated stainless steel crown – permanent tooth	\$25
D2932	Prefabricated resin crown	\$45
D2933	Prefabricated stainless steel crown with resin window	\$45
D2940	Protective restoration	\$0
D2941	Interim therapeutic restoration – primary dentition	\$0
D2950	Core buildup, including any pins when required	\$80
D2951	Pin retention – per tooth, in addition to restoration	\$15
D2952	Post and core in addition to crown, indirectly fabricated	\$70
D2953	Each additional indirectly fabricated post – same tooth	\$70
D2954	Prefabricated post and core in addition to crown	\$70
D2955	Post removal	\$40
D2957	Each additional prefabricated post – same tooth	\$65
D2960	Labial veneer (resin laminate) – chairside	\$285
D2961	Labial veneer (resin laminate) – laboratory	\$340
D2962	Labial veneer (porcelain laminate) – laboratory	\$380
D2971	Additional procedures to construct new crown under existing partial denture framework	\$50

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D2980	Crown repair necessitated by restorative material failure	\$0
D2981	Inlay repair necessitated by restorative material failure	\$0
D2982	Onlay repair necessitated by restorative material failure	\$0
D2983	Veneer repair necessitated by restorative material failure	\$0
D2990	Resin infiltration of incipient smooth surface lesions	\$0
Endodontics		
	• All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	\$10
D3120	Pulp cap – indirect (excluding final restoration)	\$10
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$45
D3221	Pulpal debridement, primary and permanent teeth	\$55
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$40
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	\$45
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$45
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$225
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$240
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$350
D3331	Treatment of root canal obstruction; non-surgical access	\$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$225
D3333	Internal root repair of perforation defects	\$85
D3346	Retreatment of previous root canal therapy – anterior	\$275
D3347	Retreatment of previous root canal therapy - premolar	\$325
D3348	Retreatment of previous root canal therapy – molar	\$375
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	\$105
D3352	Apexification/recalcification – interim medication replacement	\$105
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$105
D3355	Pulpal regeneration - initial visit	\$110
D3356	Pulpal regeneration - interim medication replacement	\$55
D3357	Pulpal regeneration - completion of treatment	\$110
D3410	Apicoectomy – anterior	\$215
D3421	Apicoectomy - premolar (first root)	\$225
D3425	Apicoectomy – molar (first root)	\$260
D3426	Apicoectomy (each additional root)	\$125
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	\$180

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	\$95
D3430	Retrograde filling – per root	\$75
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	\$125
D3741	Surgical repair of root resorption –anterior	\$162
D3472	Surgical repair of root resorption – premolar	\$169
D3473	Surgical repair of root resorption – molar	\$195
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	\$154
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	\$154
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	\$154
D3910	Surgical procedure for isolation of tooth with rubber dam	\$0
D3920	Hemisection (including any root removal), not including root canal therapy	\$105
D3950	Canal preparation and fitting of preformed dowel or post	\$15
Periodontics		
	<ul style="list-style-type: none"> Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us. 	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	\$205
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	\$155
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$0
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	\$240
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	\$188
D4245	Apically positioned flap	\$165
D4249	Clinical crown lengthening – hard tissue	\$270
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$375
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$296
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	\$180
D4264	Bone replacement graft – retained natural tooth – each additional site in	\$95

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SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	quadrant	
D4265	Biologic materials to aid in soft and osseous tissue regeneration	\$95
D4266	Guided tissue regeneration – resorbable barrier, per site	\$215
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	\$255
D4268	Surgical revision procedure, per tooth	\$0
D4270	Pedicle soft tissue graft procedure	\$285
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)	\$100
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$380
D4276	Combined connective tissue and double pedicle graft, per tooth	\$75
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	\$295
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	\$155
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
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
D4320	Provisional splinting – intracoronal	\$95
D4321	Provisional splinting – extracoronal	\$95
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$70
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$55
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$70
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	\$75
D4910	Periodontal maintenance	\$70
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$0
	• Additional periodontal maintenance procedures (beyond 2 per 12 months)	\$70
	• Periodontal charting for planning treatment of periodontal disease	\$0
	• Periodontal hygiene instruction	\$0

Removable Prosthodontics

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	• Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service.	
D5110	Complete denture – maxillary	\$525
D5120	Complete denture – mandibular	\$525
D5130	Immediate denture – maxillary	\$525
D5140	Immediate denture – mandibular	\$525
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	\$485
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	\$485
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$575
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$575
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).	\$485
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).	\$485
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).	\$575
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).	\$575
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$550
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	\$550
D5410	Adjust complete denture – maxillary	\$25
D5411	Adjust complete denture – mandibular	\$25
D5421	Adjust partial denture – maxillary	\$25
D5422	Adjust partial denture – mandibular	\$25
D5511	Repair broken complete denture base, mandibular	\$60
D5512	Repair broken complete denture base, maxillary	\$60
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$45
D5611	Repair resin partial denture base, mandibular	\$60
D5612	Repair resin partial denture base, maxillary	\$60
D5621	Repair cast partial framework, mandibular	\$60
D5622	Repair cast partial framework, maxillary	\$60

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D5630	Repair or replace broken retentive clasping materials – per tooth	\$80
D5640	Replace broken teeth – per tooth	\$45
D5650	Add tooth to existing partial denture	\$70
D5660	Add clasp to existing partial denture	\$80
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$165
D5710	Rebase complete maxillary denture	\$195
D5711	Rebase complete mandibular denture	\$195
D5720	Rebase maxillary partial denture	\$180
D5721	Rebase mandibular partial denture	\$180
D5730	Reline complete maxillary denture (chairside)	\$115
D5731	Reline complete mandibular denture (chairside)	\$115
D5740	Reline maxillary partial denture (chairside)	\$110
D5741	Reline mandibular partial denture (chairside)	\$110
D5750	Reline complete maxillary denture (laboratory)	\$150
D5751	Reline complete mandibular denture (laboratory)	\$150
D5760	Reline maxillary partial denture (laboratory)	\$150
D5761	Reline mandibular partial denture (laboratory)	\$150
D5810	Interim complete denture (maxillary)	\$230
D5811	Interim complete denture (mandibular)	\$230
D5820	Interim partial denture (maxillary)	\$180
D5821	Interim partial denture (mandibular)	\$195
D5850	Tissue conditioning, maxillary	\$45
D5851	Tissue conditioning, mandibular	\$45
D5862	Precision attachment, by report	\$160
D5876	Add metal substructure to acrylic full denture (per arch)	\$132
Crowns/Fixed Bridges - Per Unit		
	<ul style="list-style-type: none"> 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 the specified Co-payment for each Crown, implant or Bridge unit. 	
D6205	Pontic – indirect resin based composite	\$310
D6210	Pontic – cast high noble metal	\$350
D6211	Pontic – cast predominantly base metal	\$350
D6212	Pontic – cast noble metal	\$350
D6214	Pontic – titanium and titanium alloys	\$350
D6240	Pontic – porcelain fused to high noble metal	\$350

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SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D6241	Pontic – porcelain fused to predominantly base metal	\$350
D6242	Pontic – porcelain fused to noble metal	\$350
D6243	Pontic – porcelain fused to titanium and titanium alloys	\$350
D6245	Pontic – porcelain/ceramic	\$350
D6250	Pontic – resin with high noble metal	\$350
D6251	Pontic – resin with predominantly base metal	\$350
D6252	Pontic – resin with noble metal	\$350
D6253	Provisional pontic – further treatment or completion of diagnosis necessary prior to final impression	\$85
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$205
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$245
D6549	Resin retainer-for resin bonded fixed prosthesis	\$198
D6600	Retainer inlay – porcelain/ceramic, two surfaces	\$325
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	\$325
D6602	Retainer inlay – cast high noble metal, two surfaces	\$325
D6603	Retainer inlay – cast high noble metal, three or more surfaces	\$325
D6604	Retainer inlay – cast predominantly base metal, two surfaces	\$325
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	\$325
D6606	Retainer inlay – cast noble metal, two surfaces	\$325
D6607	Retainer inlay – cast noble metal, three or more surfaces	\$325
D6608	Retainer onlay – porcelain/ceramic, two surfaces	\$325
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	\$325
D6610	Retainer onlay – cast high noble metal, two surfaces	\$325
D6611	Retainer onlay – cast high noble metal, three or more surfaces	\$325
D6612	Retainer onlay – cast predominantly base metal, two surfaces	\$325
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	\$325
D6614	Retainer onlay – cast noble metal, two surfaces	\$325
D6615	Retainer onlay – cast noble metal, three or more surfaces	\$325
D6624	Retainer inlay – titanium	\$325
D6634	Retainer onlay – titanium	\$325
D6710	Retainer crown – indirect resin based composite	\$325
D6720	Retainer crown – resin with high noble metal	\$325
D6721	Retainer crown – resin with predominantly base metal	\$325
D6722	Retainer crown – resin with noble metal	\$325
D6740	Retainer crown – porcelain/ceramic	\$350
D6750	Retainer crown – porcelain fused to high noble metal	\$350
D6751	Retainer crown – porcelain fused to predominantly base metal	\$350
D6752	Retainer crown – porcelain fused to noble metal	\$350
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	\$350

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Code	Service	Your and Your Dependent's Co-Payment
D6780	Retainer crown – ¾ cast high noble metal	\$350
D6781	Retainer crown – ¾ cast predominantly base metal	\$350
D6782	Retainer crown – ¾ cast noble metal	\$350
D6783	Retainer crown – ¾ porcelain/ceramic	\$350
D6784	Retainer crown – ¾ titanium and titanium alloys	\$350
D6790	Retainer crown – full cast high noble metal	\$350
D6791	Retainer crown – full cast predominantly base metal	\$350
D6792	Retainer crown – full cast noble metal	\$350
D6793	Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression	\$105
D6794	Retainer crown – titanium and titanium alloys	\$350
D6930	Re-cement or re-bond fixed partial denture	\$20
D6940	Stress breaker	\$110
D6950	Precision attachment	\$195
D6980	Fixed partial denture repair necessitated by restorative material failure	\$45
Oral Surgery		
	<ul style="list-style-type: none"> • Includes routine post operative visits/treatment. • The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists. 	
D7111	Extraction, coronal remnants – primary tooth	\$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$20
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	\$60
D7220	Removal of impacted tooth – soft tissue	\$60
D7230	Removal of impacted tooth – partially bony	\$80
D7240	Removal of impacted tooth – completely bony	\$155
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$170
D7250	Removal of residual tooth roots (cutting procedure)	\$55
D7251	Coronectomy – intentional partial tooth removal	\$155
D7260	Oroantral fistula closure	\$270
D7261	Primary closure of a sinus perforation	\$275
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$95
D7280	Exposure of an unerupted tooth	\$200
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$90
D7283	Placement of device to facilitate eruption of impacted tooth	\$90
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	\$170
D7286	Incisional biopsy of oral tissue – soft	\$150

IND-DHMO-SOB

CA

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D7287	Exfoliative cytological sample collection	\$50
D7288	Brush biopsy – transepithelial sample collection	\$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$50
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$50
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$25
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$140
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$75
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
D7472	Removal of torus palatinus	\$60
D7473	Removal of torus mandibularis	\$60
D7485	Reduction of osseous tuberosity	\$60
D7510	Incision and drainage of abscess – intraoral soft tissue	\$35
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$40
D7520	Incision and drainage of abscess – extraoral soft tissue	\$40
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$40
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$505
D7953	Bone replacement graft for ridge preservation – per site	\$100
D7961	Buccal / labial frenectomy (frenulectomy)	\$110
D7962	Lingual frenectomy (frenulectomy)	\$110
D7963	Frenuloplasty	\$110
D7970	Excision of hyperplastic tissue – per arch	\$55
D7971	Excision of pericoronal gingiva	\$40
D7972	Surgical reduction of fibrous tuberosity	\$125

Orthodontics

- Benefits cover twenty-four (24) months of usual & customary Orthodontic treatment and an additional twenty-four (24) months of retention.

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	<ul style="list-style-type: none"> Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances. 	
D8010	Limited orthodontic treatment of the primary dentition	75% of UCR
D8020	Limited orthodontic treatment of the transitional dentition	75% of UCR
D8030	Limited orthodontic treatment of the adolescent dentition	75% of UCR
D8040	Limited orthodontic treatment of the adult dentition	75% of UCR
D8050	Interceptive orthodontic treatment of primary dentition	75% of UCR
D8060	Interceptive orthodontic treatment of transitional dentition	75% of UCR
D8070	Comprehensive orthodontic treatment of the transitional dentition	75% of UCR
D8080	Comprehensive orthodontic treatment of the adolescent dentition	75% of UCR
D8090	Comprehensive orthodontic treatment of the adult dentition	75% of UCR
D8210	Removable Appliance Therapy	75% of UCR
D8220	Fixed Appliance Therapy	75% of UCR
D8660	Pre-orthodontic treatment examination to monitor growth and development	75% of UCR
D8670	Periodic orthodontic treatment visit	75% of UCR
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	75% of UCR
D8681	Removable orthodontic retainer adjustment	75% of UCR
D8698	Re-cement or re-bond fixed retainer – maxillary	75% of UCR
D8699	Re-cement or re-bond fixed retainer – mandibular	75% of UCR
D8701	Repair of fixed retainer, includes reattachment – maxillary	75% of UCR
D8702	Repair of fixed retainer, includes reattachment – mandibular	75% of UCR
D8999	Unspecified orthodontic procedure, by report	75% of UCR
	<ul style="list-style-type: none"> Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models). 	75% of UCR
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$15
D9120	Fixed partial denture sectioning	\$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$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
D9239	Deep sedation/general anesthesia – first 15 minutes	\$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$60

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D9248	Non-intravenous conscious sedation	\$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$5
D9440	Office visit – after regularly scheduled hours	\$30
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9610	Therapeutic parenteral drug, single administration	\$20
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	\$30
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	\$20
D9630	Drugs or medicaments dispensed in the office for home use	\$20
D9910	Application of desensitizing medicament	\$20
D9930	Treatment of complication (post-surgical) – unusual circumstances, by report	\$20
D9942	Repair and/or reline of occlusal guard	\$40
D9943	Occlusal guard adjustment	\$10
D9944	Occlusal guard – hard appliance, full arch	\$85
D9945	Occlusal guard – soft appliance, full arch	\$85
D9946	Occlusal guard – hard appliance, partial arch	\$64
D9951	Occlusal adjustment – limited	\$30
D9952	Occlusal adjustment – complete	\$100
D9972	External bleaching – per arch	\$125
D9986	Missed appointment (less than 24-hour notice)	Not to exceed \$25
D9987	Cancelled appointment (if less than 24-hour notice, see D9986)	\$0
D9999	Unspecified adjunctive procedure, by report	Not to exceed \$25

Current Dental Terminology © American Dental Association

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

General

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

Diagnostic

1. Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.
2. All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

1. Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. 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.
3. Space maintainers are covered to age 14 once per area, per lifetime. Replacement of lost space maintainers is not a Covered Service.

Restorative Treatment

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 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 or Bridge unit.
3. There is a \$75 Co-Payment per molar, for the use of porcelain.
4. Prefabricated stainless steel Crowns or prefabricated resin Crowns are limited to no more than one (1) replacement for the same tooth surface within five (5) years.
5. Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.
6. Provisional and 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.
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.
8. Core buildups are limited to no more than once per tooth in a period of five (5) years.
9. Post and cores are limited to no more than once per tooth in a period of five (5) years.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

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

Prosthodontics

1. Relinings and rebasings are limited to one (1) every twelve (12) months.
2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist.
3. Replacement of an immediate full Denture with a permanent full Denture if the immediate full Denture cannot be made permanent and such replacement is done within twelve (12) months of the installation of the immediate full Denture.
4. Adjustments of Dentures if at least six (6) months have passed since the installation of the existing removable Denture.
5. Delivery of removable and fixed Prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
6. Tissue conditioning eligible one (1) per appliance each twenty-four (24) months.
7. Provisional and 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.
2. Materials used for canal irrigation are included in the Endodontic procedure fees.

Oral Surgery

1. The removal of asymptomatic third molars is not a Covered Service. Pathology (disease) must exist for it to be covered by the program.
2. Includes routine post operative visits/treatments.

Periodontics

1. Irrigation (such as Chlorhexidine) is included with the other services rendered that day.
2. Local chemotherapeutic agents are limited to no more than six (6) teeth per arch. Treatment plans involving more than six (6) teeth per arch require prior Plan approval.
3. Periodontal maintenance is eligible following active periodontal therapy, which includes scaling and root planing, surgery, etc.
4. Periodontal scaling and root planing is limited to not more than once per Quadrant in any twenty-four (24) month period.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

5. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.
6. Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.

Orthodontic Exclusions and Limitations

Your co-payments will be 75% of your selected SafeGuard general or specialty care dentist's usual and customary fees. If your general dentist does not provide orthodontic care, you may receive care from a SafeGuard contracted dentist whose practice is limited to orthodontic care. A listing of contracted dentists whose practice is limited to orthodontic care can be found online at www.safeguard.net, or you may call Customer Service. If you terminate coverage from the SafeGuard Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a Safeguard selected General Dentist or SafeGuard contracted orthodontist in order for the Co-Payments listed in the Plan's 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 charge of 75% of your Safeguard selected general dentist's or Safeguard contracted orthodontist's usual and customary fees.
3. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
4. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.
5. 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.
 - v. Invisalign services are excluded.

LANGUAGE ASSISTANCE

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS, are not covered.
2. Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and schedule of benefits (except for out-of-area emergency services).
3. Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (the tooth has been opened into the pulp (nerve chamber)), or full or partial Dentures for which an impression has been taken.
4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.
5. Orthognathic surgery.
6. Inpatient/outpatient hospital charges of any kind, including prescriptions or medications. General anesthesia or IV sedation is not covered for any reason if rendered in an out patient facility or hospital. Dental charges will be covered, if the procedure performed is covered by the Plan.
7. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
8. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.
9. Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.
10. Dental 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 in nature.
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.
15. Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.

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**。