MetLife

SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan* CITY OF DALLAS

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.

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

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)	$5

Code	Service	Your and Your Dependent's Co-Payment
	Diagnostic Treatment	
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
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

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
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	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	$180
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
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 associated with capture of the image, including report	$0
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	$0
D0416	Viral culture	$0
D0422	Collection and preparation of genetic sample material for labatory analysis and report	$0
D0423	Genetic test for susceptibility to diseases – specimen analysis	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
	Preventive Services	
D1110	Prophylaxis – adult	$5
●	Additional-adult prophylaxis (maximum of 2 additional per year)	$45
D1120	Prophylaxis – child	$5
●	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	$6

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$6
D1353	Sealant repair - per tooth	$6
D1354	Interim caries arresting medicament application	$3
D1510	Space maintainer – fixed – unilateral	$55
D1515	Space maintainer – fixed – bilateral	$55
D1520	Space maintainer – removable – unilateral	$60
D1525	Space maintainer – removable – bilateral	$60
D1550	Re-cement or re-bond space maintainer	$15
D1555	Removal of fixed space maintainer	$15
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$12
D2150	Amalgam – two surfaces, primary or permanent	$15
D2160	Amalgam – three surfaces, primary or permanent	$16
D2161	Amalgam – four or more surfaces, primary or permanent	$18
D2330	Resin-based composite – one surface, anterior	$15
D2331	Resin-based composite – two surfaces, anterior	$18
D2332	Resin-based composite – three surfaces, anterior	$23
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$68
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$50
D2392	Resin-based composite – two surfaces, posterior	$70
D2393	Resin-based composite – three surfaces, posterior	$90
D2394	Resin-based composite – four or more surfaces, posterior	$90
	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 the specified Co-payment for each Crown, implant or Bridge unit.	
D2750	Crown – porcelain fused to high noble metal	$255
D2751	Crown – porcelain fused to predominantly base metal	$255
D2752	Crown – porcelain fused to noble metal	$255
D2780	Crown – ¾ cast high noble metal	$255
D2781	Crown – ¾ cast predominantly base metal	$255
D2782	Crown – ¾ cast noble metal	$255
D2790	Crown – full cast high noble metal	$255
D2791	Crown – full cast predominantly base metal	$255
D2792	Crown – full cast noble metal	$255
D2794	Crown – titanium	$255
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

Code	Service	Your and Your Dependent's Co-Payment
D2920	Re-cement or re-bond crown	$15
D2930	Prefabricated stainless steel crown – primary tooth	$55
D2931	Prefabricated stainless steel crown – permanent tooth	$55
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$55
D2940	Protective restoration	$10
D2941	Interim therapeutic restoration – primary dentition	$0
D2950	Core buildup, including any pins when required	$40
D2951	Pin retention – per tooth, in addition to restoration	$36
D2952	Post and core in addition to crown, indirectly fabricated	$75
D2953	Each additional indirectly fabricated post – same tooth	$15
D2954	Prefabricated post and core in addition to crown	$65
D2955	Post removal	$15
D2957	Each additional prefabricated post – same tooth	$16
	Endodontics	
	● All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	$12
D3120	Pulp cap – indirect (excluding final restoration)	$3
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$20
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$20
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$20
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$95
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$150
D3330	Endodontic therapy, molar (excluding final restoration)	$225
D3410	Apicoectomy – anterior	$125
D3421	Apicoectomy – bicuspid (first root)	$175
D3425	Apicoectomy – molar (first root)	$185
D3426	Apicoectomy (each additional root)	$90
D3430	Retrograde filling – per root	$60
	Periodontics	
	● Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$140
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$94
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or tooth bounded spaces per quadrant	$200
D4241	Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant	$134
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$300

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$200
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$34
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$60
D4910	Periodontal maintenance	$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
	Removable Prosthodontics	
●	Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service.	
D5110	Complete denture – maxillary	$300
D5120	Complete denture – mandibular	$300
D5130	Immediate denture – maxillary	$325
D5140	Immediate denture – mandibular	$325
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$320
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$320
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$320
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$320
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350
D5410	Adjust complete denture – maxillary	$10
D5411	Adjust complete denture – mandibular	$10
D5421	Adjust partial denture – maxillary	$10
D5422	Adjust partial denture – mandibular	$10
D5510	Repair broken complete denture base	$29
D5520	Replace missing or broken teeth – complete denture (each tooth)	$22
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$30
D5630	Repair or replace broken clasp - per tooth	$30
D5640	Replace broken teeth – per tooth	$30
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture - per tooth	$45
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$288

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$288
D5710	Rebase complete maxillary denture	$100
D5711	Rebase complete mandibular denture	$100
D5720	Rebase maxillary partial denture	$100
D5721	Rebase mandibular partial denture	$100
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$95
D5751	Reline complete mandibular denture (laboratory)	$95
D5760	Reline maxillary partial denture (laboratory)	$95
D5761	Reline mandibular partial denture (laboratory)	$95
D5820	Interim partial denture (maxillary)	$110
D5821	Interim partial denture (mandibular)	$110
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
	Crowns/Fixed Bridges - 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 $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.	
D6210	Pontic – cast high noble metal	$255
D6211	Pontic – cast predominantly base metal	$255
D6212	Pontic – cast noble metal	$255
D6214	Pontic – titanium	$255
D6240	Pontic – porcelain fused to high noble metal	$255
D6241	Pontic – porcelain fused to predominantly base metal	$255
D6242	Pontic – porcelain fused to noble metal	$255
D6250	Pontic – resin with high noble metal	$255
D6251	Pontic – resin with predominantly base metal	$255
D6252	Pontic – resin with noble metal	$255
D6720	Retainer crown – resin with high noble metal	$255
D6721	Retainer crown – resin with predominantly base metal	$255
D6750	Retainer crown – porcelain fused to high noble metal	$255
D6751	Retainer crown – porcelain fused to predominantly base metal	$255
D6752	Retainer crown – porcelain fused to noble metal	$255
D6780	Retainer crown – ¾ cast high noble metal	$255
D6781	Retainer crown – ¾ cast predominantly base metal	$250
D6782	Retainer crown – ¾ cast noble metal	$250
D6790	Retainer crown – full cast high noble metal	$250
D6791	Retainer crown – full cast predominantly base metal	$255

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D6792	Retainer crown – full cast noble metal	$255
D6793	Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression	$55
D6794	Retainer crown – titanium	$255
D6930	Re-cement or re-bond fixed partial denture	$10
D6940	Stress breaker	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$45
	Oral Surgery	
	● Includes routine post operative visits/treatment.	
	● The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists.	
D7111	Extraction, coronal remnants – deciduous tooth	$15
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$25
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partially bony	$65
D7240	Removal of impacted tooth – completely bony	$110
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$110
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$65
D7280	Surgical access of an unerupted tooth	$65
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$30
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$60
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$40
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)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$35
D7910	Suture of recent small wounds up to 5 cm	$0
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	$60
	Orthodontics	
	● Benefits cover twenty-four (24) months of usual & customary Orthodontic treatment and an additional twenty-four (24) months of retention.	
	● Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances.	
D8010	Limited orthodontic treatment of the primary dentition	$1,300
D8020	Limited orthodontic treatment of the transitional dentition	$1,300

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D8030	Limited orthodontic treatment of the adolescent dentition	$1,300
D8040	Limited orthodontic treatment of the adult dentition	$1,300
D8050	Interceptive orthodontic treatment of the primary dentition (banding)	$1,300
D8060	Interceptive orthodontic treatment of the transitional dentition (banding)	$1,300
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,400
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,400
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,600
D8210	Removable appliance therapy	$560
D8220	Fixed appliance therapy	$560
D8660	Pre-orthodontic treatment examination to monitor growth and development	$150
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$95
D8681	Removable orthodontic retainer adjustment	$0
D8693	Re-cement or re-bond fixed retainers	$0
D8694	Repair of fixed retainers, includes reattachment	$0
●	There is a Co-Payment of $250 for Orthodontic treatment planning and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models).	
●	There is a Co-Payment of $25 per visit for Orthodontic visits beyond twenty-four (24) months of active treatment or retention.	
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$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 deep sedation or general anesthesia	$0
D9223	Deep sedation/general anesthesia – each 15 minute increment	$60
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$10
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$60
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9450	Case presentation, detailed and extensive treatment planning	$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
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9943	Occlusal guard adjustment	$10
D9951	Occlusal adjustment – limited	$15
D9952	Occlusal adjustment – complete	$50

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D9986	Missed appointment (less than 24-hr notice)	$25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0

Current Dental Terminology © American Dental Association

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

General

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

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

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

Diagnostic

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

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

Preventive

1. Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. 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

Crowns, Implants and 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. 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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

6. 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.

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.

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 or Specialty Care Dentist.

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

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

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

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

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

Implant Services

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

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

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

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

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

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.

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

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

Orthodontics

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

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

3. Orthodontic treatment must be provided by a Selected General Dentist or Specialty Care Dentist whose specialty is orthodontics or pediatric dentistry for the 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. Continuing Orthodontic treatment is available if You or Your Dependent qualify by enrolling within 30 days of the Effective Date for an eligible contractholder; You or Your Dependent had Orthodontic coverage under the contractholder's prior plan and were in active Orthodontic treatment, covered by that Plan, as of the Effective Date of this group contract. Upon receipt of a completed Continuing Orthodontic Form by Us, with all supporting documentation, We will accept liability for continuing payment of the remaining balance owed, up to a maximum of $1,500 times the percentage of the total treatment remaining as of this group contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS. The Continuing Orthodontic provision is not available:

    - thirty (30) days after this group contract's Effective Date;
    - to a person who enrolls after the group contract's Effective Date; or
    - to a person who is not in active Orthodontic treatment as of the Effective Date of this group contract.

DENTAL BENEFITS: EXCLUSIONS

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

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

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

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

5. Orthognathic surgery.

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

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

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

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

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

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

12. Dental services considered Experimental in nature. 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.

14. The following are not included as Orthodontic benefits:

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