MetLife

SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan* SmileSaver 3000

Principal Benefits and Coverages: The following services are the principal benefits to which Members are entitled. Only these procedures are provided for, either partially or totally by the Plan. The Member may be responsible for a co-payment for these procedures. Please reference your Evidence of Coverage to fully understand what is meant by Coverage for a given procedure. If a service is requested and provided to a Member and the procedure is not listed in this Schedule of Benefits, the Member shall pay the dentist his or her usual and customary fee for the treatment received. There may be some procedures that are listed in this document that may not be available at all locations due to individual dentist's scope of practice.

Other Charges: The Member is responsible for the Co-payments for services listed in the following Schedule of Benefits.

Specialty Care Information: During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist.

*Your SafeGuard selected general dentist is responsible for coordinating your dental care, and if necessary, referring you to a SafeGuard contracted specialist, and will submit all required documentation for any necessary referral.

Pedodontics: Pedodontic services listed as covered services in this Schedule of Benefits are available at a Specialist at 75% of that provider's usual fee for this service for children under the age of six (6) when referred by a SafeGuard selected general dentist.

♦ If you choose to receive this service from a SafeGuard contracted specialty care provider (periodontics, oral surgery, endodontics, orthodontics), your co-payment will be 75% of that provider's usual fee for this service.

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
	Diagnostic Treatment		
	• Bitewings are limited to 1 per 12 months.		
	• Full mouth x-rays are limited to 1 per 3 years.		
	• Panoramic x-rays are limited to 1 per 3 years.		
	• Orthodontic x-rays are not covered.		
D0120	Periodic oral evaluation - established patient	$0	♦
D0140	Limited oral evaluation - problem focused	$0	$40
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0	$40
D0150	Comprehensive oral evaluation - new or established patient	$0	$40
D0171	Re-evaluation – post-operative office visit	$0	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$5	$5
	• Office visit - per visit (including all fees for sterilization and/or infection control)	$0	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
	Radiographs/Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series of radiographic images	$0	$30
D0220	Intraoral – periapical first radiographic image	$0	$14
D0230	Intraoral – periapical each additional radiographic image	$0	$6
D0240	Intraoral – occlusal 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	♦
D0330	Panoramic radiographic image	$0	$22
	Tests and Examinations		
D0460	Pulp vitality tests	$0	♦
D0470	Diagnostic casts	$5	♦
	Preventive Services		
	● *Prophylaxis are limited to 2 per 12 months.*		
	● Fluoride treatments are limited to 2 per 12 months for children under age 18.		
	● Space maintainers are limited to children under age 14.		
D1110	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.	$0	♦
D1120	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.	$0	♦
D1206	Topical application of fluoride varnish	$0	♦
D1208	Topical application of fluoride – excluding varnish	$0	♦
D1330	Oral hygiene instructions	$0	♦
D1351	Sealant – per tooth	$6	♦
D1510	Space maintainer – fixed, unilateral – per quadrant excludes a distal shoe space maintainer.	$40	♦
D1516	Space maintainer – fixed – bilateral, maxillary	$80	♦
D1517	Space maintainer – fixed – bilateral, mandibular	$80	♦
D1520	Space maintainer – removable, unilateral – per quadrant	$40	♦
D1526	Space maintainer – removable – bilateral, maxillary	$90	♦
D1527	Space maintainer – removable – bilateral, mandibular	$90	♦
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$10	♦
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$10	♦
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$10	♦
D1556	Removal of fixed unilateral space maintainer – per quadrant	$10	♦
D1557	Removal of fixed bilateral space maintainer - maxillary	$10	♦
D1558	Removal of fixed bilateral space maintainer - mandibular	$10	♦
	Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	$9	♦
D2150	Amalgam – two surfaces, primary or permanent	$14	♦

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
D2160	Amalgam – three surfaces, primary or permanent	$22	♦
D2161	Amalgam – four or more surfaces, primary or permanent	$25	♦
D2330	Resin-based composite – one surface, anterior	$25	♦
D2331	Resin-based composite – two surfaces, anterior	$35	♦
D2332	Resin-based composite – three surfaces, anterior	$40	♦
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$50	♦
D2391	Resin-based composite – one surface, posterior	$60	♦
D2392	Resin-based composite – two surfaces, posterior	$85	♦
D2393	Resin-based composite – three surfaces, posterior	$100	♦
D2394	Resin-based composite – four or more surfaces, posterior	$100	♦
	Crowns		
●	*Cost of noble or high noble metal (gold, etc.) may be charged extra when used, not to exceed actual laboratory cost of metal.*		
D2750	Crown – porcelain fused to high noble metal	$120	♦
D2751	Crown – porcelain fused to predominantly base metal	$120	♦
D2752	Crown – porcelain fused to noble metal	$120	♦
●	There is an additional $105 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on posterior teeth (molars or bicuspids).		
●	There is an additional $275 co-payment per crown/bridge unit in addition to regular co-payments for elective procedures on anterior or posterior teeth.		
D2753	Crown - porcelain fused to titanium and titanium alloys	$120	♦
D2780	Crown – ¾ cast high noble metal	$115	♦
D2781	Crown – ¾ cast predominantly base metal	$115	♦
D2782	Crown – ¾ cast noble metal	$115	♦
D2791	Crown – full cast predominantly base metal	$115	♦
D2792	Crown – full cast noble metal	$115	♦
●	There is an additional $210 co-payment per crown/bridge unit in addition to regular co-payments for elective procedures on anterior or posterior teeth.		
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$12	♦
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$12	♦
D2920	Re-cement or re-bond crown	$12	♦
D2930	Prefabricated stainless steel crown – primary tooth	$40	♦
D2931	Prefabricated stainless steel crown – permanent tooth	$40	♦
D2940	Protective restoration	$0	♦
D2950	Core buildup, including any pins when required	$0	♦
D2951	Pin retention – per tooth, in addition to restoration	$0	♦
D2952	Post and core in addition to crown, indirectly fabricated	$50	♦
D2954	Prefabricated post and core in addition to crown	$30	♦
D2962	Labial veneer (porcelain laminate) – laboratory	$350	♦

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
D2970	Temporary crown (fractured tooth)	$0	♦
D2971	Additional procedures to construct new crown under existing partial denture framework	$102	♦
	Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$0	♦
D3120	Pulp cap – indirect (excluding final restoration)	$0	♦
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$15	♦
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$100	♦
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$135	♦
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$185	♦
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$12	♦
D3352	Apexification/recalcification – interim medication replacement	$12	♦
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$12	♦
D3410	Apicoectomy – anterior	$120	♦
D3421	Apicoectomy - premolar (first root)	$120	♦
D3425	Apicoectomy – molar (first root)	$120	♦
D3426	Apicoectomy (each additional root)	$120	♦
D3430	Retrograde filling – per root	$30	♦
D3450	Root amputation – per root	U&C	♦
D3920	Hemisection (including any root removal), not including root canal therapy	U&C	♦
	Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$85	♦
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$30	♦
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$125	♦
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$100	♦
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$26	$65
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$21	$52
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$35	♦
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$26	♦
D4910	Periodontal maintenance	$30	♦

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
●	Initial periodontal charting for moderate to advances cases	$5	♦
	Removable Prosthodontics		
	Includes all adjustments for up to six (6) months post-delivery.		
D5110	Complete denture – maxillary	$120	♦
D5120	Complete denture – mandibular	$120	♦
D5130	Immediate denture – maxillary	$175	♦
D5140	Immediate denture – mandibular	$175	♦
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$110	♦
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$110	♦
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120	♦
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120	♦
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$110	♦
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$110	♦
D5410	Adjust complete denture – maxillary	$0	♦
D5411	Adjust complete denture – mandibular	$0	♦
D5421	Adjust partial denture – maxillary	$0	♦
D5422	Adjust partial denture – mandibular	$0	♦
D5510	Repair broken complete denture base	$20	♦
D5520	Replace missing or broken teeth – complete denture (each tooth)	$20	♦
D5610	Repair resin denture base	$15	♦
D5620	Repair cast framework	$40	♦
D5630	Repair or replace broken retentive clasping materials – per tooth	$20	♦
D5640	Replace broken teeth – per tooth	$20	♦
D5650	Add tooth to existing partial denture	$20	♦
D5660	Add clasp to existing partial denture - per tooth	$15	♦
D5710	Rebase complete maxillary denture	$70	♦
D5711	Rebase complete mandibular denture	$70	♦
D5720	Rebase maxillary partial denture	$70	♦
D5721	Rebase mandibular partial denture	$70	♦
D5730	Reline complete maxillary denture (chairside)	$0	♦
D5731	Reline complete mandibular denture (chairside)	$0	♦
D5740	Reline maxillary partial denture (chairside)	$0	♦
D5741	Reline mandibular partial denture (chairside)	$0	♦
D5750	Reline complete maxillary denture (laboratory)	$65	♦
D5751	Reline complete mandibular denture (laboratory)	$65	♦
D5760	Reline maxillary partial denture (laboratory)	$65	♦

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
D5761	Reline mandibular partial denture (laboratory)	$65	♦
D5820	Interim partial denture (maxillary)	$70	♦
D5821	Interim partial denture (mandibular)	$70	♦
D5850	Tissue conditioning, maxillary	$15	♦
D5851	Tissue conditioning, mandibular	$15	♦
	Crowns/Fixed Bridges - Per Unit		
	• *Cost of noble or high noble metal (gold, etc.) may be charged extra when used, not to exceed actual laboratory cost of metal.*		
	• There is an additional $105 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on posterior teeth (molars or bicuspids).		
D6210	Pontic – cast high noble metal	$115	♦
D6211	Pontic – cast predominantly base metal	$115	♦
D6212	Pontic – cast noble metal	$115	♦
D6240	Pontic – porcelain fused to high noble metal	$120	♦
D6241	Pontic – porcelain fused to predominantly base metal	$120	♦
D6242	Pontic – porcelain fused to noble metal	$120	♦
D6243	Pontic – porcelain fused to titanium and titanium alloys	$120	♦
D6750	Retainer crown – porcelain fused to high noble metal	$120	♦
D6751	Retainer crown – porcelain fused to predominantly base metal	$120	♦
D6752	Retainer crown – porcelain fused to noble metal	$120	♦
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$120	♦
D6780	Retainer crown – ¾ cast high noble metal	$115	♦
D6781	Retainer crown – ¾ cast predominantly base metal	$115	♦
D6782	Retainer crown – ¾ cast noble metal	$115	♦
D6784	Retainer crown – ¾ titanium and titanium alloys	$115	♦
D6790	Retainer crown – full cast high noble metal	$115	♦
D6791	Retainer crown – full cast predominantly base metal	$115	♦
D6792	Retainer crown – full cast noble metal	$115	♦
D6930	Re-cement or re-bond fixed partial denture	$5	♦
	Oral Surgery		
D7111	Extraction, coronal remnants – primary tooth	$9	$32
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10	$35
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$25	$60
D7220	Removal of impacted tooth – soft tissue	$35	$100
D7230	Removal of impacted tooth – partially bony	$50	$125
D7240	Removal of impacted tooth – completely bony	$65	$150
D7250	Removal of residual tooth roots (cutting procedure)	$25	♦
D7510	Incision and drainage of abscess – intraoral soft tissue	U&C	♦

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	U&C	♦
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	U&C	♦
D7910	Suture of recent small wounds up to 5 cm	U&C	♦
D7961	Buccal / labial frenectomy (frenulectomy)	$35	$50
D7962	Lingual frenectomy (frenulectomy)	$35	$50
D7963	Frenuloplasty	$35	$50
D7970	Excision of hyperplastic tissue – per arch	U&C	♦
	Orthodontics		
D8030	Limited orthodontic treatment of the adolescent dentition	U&C	$1,000
D8040	Limited orthodontic treatment of the adult dentition	U&C	$1,400
D8080	Comprehensive orthodontic treatment of the adolescent dentition	U&C	$1,600
D8090	Comprehensive orthodontic treatment of the adult dentition	U&C	$1,950
D8210	Removable appliance therapy	$40	♦
D8220	Fixed appliance therapy	$60	♦
D8660	Pre-orthodontic treatment examination to monitor growth and development	U&C	$40
D8670	Periodic orthodontic treatment visit	$10	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	U&C	$450
D8698	Re-cement or re-bond fixed retainer – maxillary	U&C	$0
D8699	Re-cement or re-bond fixed retainer – mandibular	U&C	$0
	Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$15	$45
D9120	Fixed partial denture sectioning	$0	♦
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	♦
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	$0
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$40	$40
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	$5	$5
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0	$0
D9941	Fabrication of athletic mouthguard	$75	♦
D9942	Repair and/or reline of occlusal guard	$30	♦
D9951	Occlusal adjustment – limited	$12	♦
D9972	External bleaching – per arch – performed in office	$175	♦
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25	Not to exceed $25

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment When Services Performed by Contracted General Dentist	Co-payment When Services Performed by Contracted Specialist
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0	$0
●	Record transfer - transfer of all materials with less than a full mouth x-ray	$10	♦
●	Record transfer - transfer of all materials with a full mouth x-ray	$20	♦

♦ If you choose to receive this service from a SafeGuard contracted specialty care provider (periodontics, oral surgery, endodontics, orthodontics), your co-payment will be 75% of that provider's usual fee for this service.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

The limitations listed below apply to your dental plan. However, you may elect to have any treatment performed at the dentist's regular fee:

1. Services performed by a general dentist or specialty care dentist, not contracted with SafeGuard, without prior approval by SafeGuard (except for out of area emergency services).

2. Routine and periodic examinations are limited to two (2) per twelve (12) months, per enrolled Member.

3. Routine prophylaxis procedures are limited to two (2) per twelve (12) months.

4. Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one (1) series of films in any twelve (12) consecutive month period. Full mouth radiographs (x-rays), in conjunction with periodic examinations, are limited to once every three (3) years. Panoramic films are limited to once every three (3) years.

5. Fluoride treatment is limited to enrolled Members under the age of eighteen (18) years, and two (2) per twelve (12) months.

6. Periodontal scaling and root planing and periodontal maintenance procedures are limited to one (1) course of therapy during any twelve (12) month period.

7. Space maintainers are limited to enrolled Members under the age of fourteen (14) years.

8. Partial dentures are not eligible for replacement within three (3) years of original placement unless required as a result of tooth loss which cannot be restored by modification of the existing partial denture. Crowns, bridges, and/or complete dentures are not eligible for replacement within five (5) years of original placement.

9. Complete upper and/or lower dentures are covered only once within any five (5) year period. Replacement will be provided for an existing denture only if it is unsatisfactory and cannot be made satisfactory. Complete or partial upper and/or lower dentures are limited to the benefit level for a standard procedure. If a more personalized or specialized treatment (such as precision attachments, overlays, implants, personalization or characterization) is chosen by the patient and the dentist, the patient will be responsible for all additional charges.

10. Complete and/or partial denture relines are limited to one (1) per denture during a twelve (12) month period.

11. Use of alloys with 25% or more noble metal content for any restorative procedure are considered optional and, if used, the additional cost for such alloy is the Member's financial responsibility.

12. Pedodontic services are available to eligible Members under the age of six (6) years, if his or her assigned Participating General Dentist requests the referral to the participating Specialist after examining the patient. Pedodontic benefits are available at a reduced rate from participating dental offices.

13. Anterior teeth are defined as the maxillary and mandibular incisors and canines.

DENTAL BENEFITS: EXCLUSIONS

The following dental services and procedures are not included in this dental plan and there is no coverage for these items. However, you may elect to have any treatment performed at the dentist's regular fee:

1. Any procedure not specifically listed as a covered benefit.

2. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, medical health insurance, worker's compensation or occupational disease law, even if the patient did not claim those benefits.

3. Care or treatment which is obtained from, or for which payment is made by, any Federal, State, County, Municipal, or other governmental agency, including any foreign government.

4. Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not the result of war.

5. Any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party is not covered.

6. Dental treatment or expenses incurred or in connection with any dental procedures started prior to the Member's effective date under this Plan or after termination of the Member's coverage. Example: teeth prepared for crowns, root canal treatment in progress, orthodontic treatment in progress.

7. Dispensing of drugs not normally supplied in the dental office.

8. Hospital and associated physician charges or any kind of charges for any dental treatment or costs associated with treatment as a result of an accident. This plan does not provide emergency medical care to its members, except, if applicable, in certain specifically identified instances. Members are encouraged to use the 911 emergency response system in areas where the system is established and operating when the Member has an emergency medical condition that requires an emergency response.

9. All treatment of fractures and dislocations.

10. Extractions for orthodontic purposes.

11. General anesthesia, inhalation sedation, intravenous sedation, or intramuscular sedation.

12. Dental treatment or expenses incurred in conjunction with the correction of congenital or developmental malformations.

13. Histopathological exams, treatment and/or removal of cysts, tumors, neoplasms, malignancies and foreign bodies.

14. Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, alveoloplasty, vestibuloplasty, or osteotomy procedures.

15. Charges for any dental treatment, because the Member is unwilling or incapable of having treatment performed in the assigned general dentist or specialist office.

16. Dental procedures and charges incurred as part of implants (placement or removal) and prosthetic devices placed on implants (fixed or removable, example: bridges, crowns, dentures).

17. Replacement of lost or stolen dentures, crown and bridgework, or other dental appliances.

DENTAL BENEFITS: EXCLUSIONS (continued)

18. Precision attachments and stress breakers.

19. Crown lengthening surgical procedures.

20. Dental treatment or procedures required in conjunction with altering vertical dimension, replacing tooth structure lost by attrition, erosion or abrasion.

21. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction (more than six (6) units of crown and/or bridgework in one (1) arch or more than ten (10) units total). Extensive oral rehabilitation or reconstruction is available at the dentist's regular fee.

22. Diagnosis or treatment by any method of any condition related to the jaw joint, temporomandibular joint (TMJ) or associated musculature, nerves and other tissues.

23. Oral physio-therapy, dietary or saliva analysis and dietary instruction.

24. The treating dentist shall have the right to discontinue further treatment of a Member who continually fails to keep appointments or who fails to follow their prescribed course of treatment.

25. Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect, and any dental services started by a non-participating dentist will not be the responsibility of the participating dental office or the Plan for completion or compensation.

26. A dental treatment plan which in the opinion of the Participating Dentist, is not dentally necessary, will not produce a beneficial result, or has a poor prognosis.

27. Endodontic retreatment of previous root canal therapy is not a covered benefit.

Orthodontic Exclusions & Limitations:

Limitations

A. Child co-payments apply only to those members up to age nineteen (19). Age nineteen (19) and older are considered adults and are subject to adult co-payments.

B. Treatment co-payments are for twenty-four (24) months of treatment. Treatment in excess of twenty-four (24) months (extended treatment) is available at usual and customary fees, payable until treatment is completed (retainers are placed). If the patient is in active treatment and the member elects to change providers, the member may incur additional expenses.

C. Member and his or her eligible dependent must remain on the Plan during the period of time the member or his or her eligible dependent is undergoing orthodontic treatment. An early termination will result in usual and customary charges for all unfinished work.

D. Orthodontic treatment must be provided by participating Orthodontist.

Exclusions

A. The following are not benefits included as orthodontia:
   1. X-rays for orthodontic purposes
   2. Tracings and photographs
   3. Phase I orthodontic treatment (prior to full mouth banding)

B. Treatment in progress started prior to a Member's eligibility under this plan.

C. Surgical procedures for orthodontic treatment.

DENTAL BENEFITS: EXCLUSIONS (continued)

D. Severe or mutilated malocclusions.

E. Retreatment of orthodontic cases.

F. Changes in treatment necessitated by accident of any kind.

G. Hospital charges, or treatment in a hospital.

H. Dispensing of drugs not normally supplied in a dental office.

I. Treatment of temporomandibular joint (TMJ) disturbances, hormonal imbalances, cleft palate, micrognathia, macroglossia, and myofunctional therapies are excluded services.

J. Replacement of lost or broken appliances.

K. Extractions for orthodontic purposes.

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**。