MetLife

SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan* MET290

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
•	Broken Appointment (less than 24-hr notice)	Not to exceed $25
•	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
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	Extraoral – first radiographic image	$0
D0260	Extraoral – each additional radiographic image	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
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	Cephalometric radiographic image	$0
D0350	Oral/facial photographic images	$0
D0363	Cone beam – three dimensional image reconstruction using existing data, includes multiple images	$160
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
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, preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	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	$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	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1510	Space maintainer – fixed – unilateral	$25
D1515	Space maintainer – fixed – bilateral	$25
D1520	Space maintainer – removable – unilateral	$35
D1525	Space maintainer – removable – bilateral	$35
D1550	Re-cementation of 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	$20
D2160	Amalgam – three surfaces, primary or permanent	$23
D2161	Amalgam – four or more surfaces, primary or permanent	$25
D2330	Resin-based composite – one surface, anterior	$12
D2331	Resin-based composite – two surfaces, anterior	$20
D2332	Resin-based composite – three surfaces, anterior	$23
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$25
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$30
D2392	Resin-based composite – two surfaces, posterior	$45
D2393	Resin-based composite – three surfaces, posterior	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65
	Crowns	
•	An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 Co-Payment per molar, for the use of porcelain.	
•	Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional $125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, implant or Bridge unit.	
D2510	Inlay – metallic – one surface	$270
D2520	Inlay – metallic – two surfaces	$270

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D2530	Inlay – metallic – three or more surfaces	$270
D2542	Onlay – metallic – two surfaces	$270
D2543	Onlay – metallic – three surfaces	$270
D2544	Onlay – metallic – four or more surfaces	$270
D2610	Inlay – porcelain/ceramic – one surface	$290
D2620	Inlay – porcelain/ceramic – two surfaces	$290
D2630	Inlay – porcelain/ceramic – three or more surfaces	$290
D2642	Onlay – porcelain/ceramic – two surfaces	$290
D2643	Onlay – porcelain/ceramic – three surfaces	$290
D2644	Onlay – porcelain/ceramic – four or more surfaces	$290
D2650	Inlay – resin-based composite – one surface	$290
D2651	Inlay – resin-based composite – two surfaces	$290
D2652	Inlay – resin-based composite – three or more surfaces	$290
D2662	Onlay – resin-based composite – two surfaces	$290
D2663	Onlay – resin-based composite – three surfaces	$290
D2664	Onlay – resin-based composite – four or more surfaces	$290
D2710	Crown – resin-based composite (indirect)	$290
D2712	Crown – ¾ resin-based composite (indirect)	$290
D2720	Crown – resin with high noble metal	$290
D2721	Crown – resin with predominantly base metal	$290
D2722	Crown – resin with noble metal	$290
D2740	Crown – porcelain/ceramic substrate	$310
D2750	Crown – porcelain fused to high noble metal	$290
D2751	Crown – porcelain fused to predominantly base metal	$290
D2752	Crown – porcelain fused to noble metal	$290
D2780	Crown – ¾ cast high noble metal	$290
D2781	Crown – ¾ cast predominantly base metal	$290
D2782	Crown – ¾ cast noble metal	$290
D2783	Crown – ¾ porcelain/ceramic	$290
D2790	Crown – full cast high noble metal	$290
D2791	Crown – full cast predominantly base metal	$290
D2792	Crown – full cast noble metal	$290
D2794	Crown – titanium	$290
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$85
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
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

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D2940	Protective restoration	$0
D2950	Core buildup, including any pins	$75
D2951	Pin retention – per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50
D2953	Each additional indirectly fabricated post – same tooth	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$10
D2957	Each additional prefabricated post – same tooth	$30
D2960	Labial veneer (resin laminate) – chairside	$250
D2961	Labial veneer (resin laminate) – laboratory	$300
D2962	Labial veneer (porcelain laminate) – laboratory	$350
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
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)	$5
D3120	Pulp cap – indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$40
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)	$40
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$40
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$115
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$185
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$265
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$230
D3347	Retreatment of previous root canal therapy – bicuspid	$280
D3348	Retreatment of previous root canal therapy – molar	$325
D3351	Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space, disinfection, etc.)	$70

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D3352	Apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space, disinfection, etc.)	$70
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3354	Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	$70
D3410	Apicoectomy/periradicular surgery – anterior	$95
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$95
D3425	Apicoectomy/periradicular surgery – molar (first root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$80
D3430	Retrograde filling – per root	$60
D3450	Root amputation – per root	$110
D3460	Endodontic endosseous implant	$555
D3910	Surgical procedure for isolation of tooth with rubber dam	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
	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	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$100
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$100
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$170
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$130
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening – hard tissue	$160
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$330
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$248
D4263	Bone replacement graft – first site in quadrant	$180
D4264	Bone replacement graft – each additional site in quadrant	$95
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	$250
D4273	Subepithelial connective tissue graft procedures, per tooth	$75

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Soft tissue allograft	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$75
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft	$260
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$260
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
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	$38
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$50
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$65
D4910	Periodontal maintenance	$40
D4920	Unscheduled dressing change (by someone other than treating dentist)	$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	$440
D5120	Complete denture – mandibular	$440
D5130	Immediate denture – maxillary	$440
D5140	Immediate denture – mandibular	$440
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$405
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$405
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$480
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$480
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$480
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$480
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	$360
D5410	Adjust complete denture – maxillary	$20
D5411	Adjust complete denture – mandibular	$20
D5421	Adjust partial denture – maxillary	$20
D5422	Adjust partial denture – mandibular	$20
D5510	Repair broken complete denture base	$50
D5520	Replace missing or broken teeth – complete denture (each tooth)	$40
D5610	Repair resin denture base	$50

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D5620	Repair cast framework	$50
D5630	Repair or replace broken clasp	$70
D5640	Replace broken teeth – per tooth	$40
D5650	Add tooth to existing partial denture	$60
D5660	Add clasp to existing partial denture	$70
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	$125
D5711	Rebase complete mandibular denture	$125
D5720	Rebase maxillary partial denture	$125
D5721	Rebase mandibular partial denture	$125
D5730	Reline complete maxillary denture (chairside)	$100
D5731	Reline complete mandibular denture (chairside)	$100
D5740	Reline maxillary partial denture (chairside)	$90
D5741	Reline mandibular partial denture (chairside)	$90
D5750	Reline complete maxillary denture (laboratory)	$130
D5751	Reline complete mandibular denture (laboratory)	$130
D5760	Reline maxillary partial denture (laboratory)	$130
D5761	Reline mandibular partial denture (laboratory)	$130
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$160
D5821	Interim partial denture (mandibular)	$170
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
D5862	Precision attachment, by report	$160
	Implant Services	
	Pre-Surgical Services	
D6190	Radiographic/surgical implant index, by report	$130
	Surgical Services	
D6010	Surgical placement of implant body; endosteal implant	$1,005
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$770
D6040	Surgical placement: eposteal implant	$1,860
D6050	Surgical placement: transosteal implant	$1,170
D6051	Interim abutment	$245
D6100	Implant removal, by report	$240
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	$130
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	$248
D6103	Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic	$100

Code	Service	Your and Your Dependent's Co-Payment
	materials to aid in osseous regeneration	
D6104	Bone graft at time of implant placement	$100
	Implant Supported Prosthetics	
•	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.	
D6053	Implant/abutment supported removable denture for completely endentulous arch	$995
D6054	Implant/abutment supported removable denture for partially endentulous arch	$945
D6055	Connecting bar – implant supported or abutment supported	$345
D6056	Prefabricated abutment – includes modification and placement	$245
D6057	Custom fabricated abutment – includes placement	$335
D6058	Abutment supported porcelain/ceramic crown	$685
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$660
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$640
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$645
D6062	Abutment supported cast metal crown (high noble metal)	$655
D6063	Abutment supported cast metal crown (predominantly base metal)	$640
D6064	Abutment supported cast metal crown (noble metal)	$720
D6065	Implant supported porcelain/ceramic crown	$725
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$700
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$725
D6068	Abutment supported retainer for porcelain/ceramic FPD	$680
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$680
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$595
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$635
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$625
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$445
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$640
D6075	Implant supported retainer for ceramic FPD	$720
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$700
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$510
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$2,380
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$1,410
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$55
D6090	Repair implant supported prosthesis, by report	$190

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$170
D6092	Recement implant/abutment supported crown	$50
D6093	Recement implant/abutment supported fixed partial denture	$70
D6094	Abutment supported crown (titanium)	$650
D6095	Repair implant abutment, by report	$140
D6194	Abutment supported retainer crown for FPD (titanium)	$520
	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.	
D6205	Pontic – indirect resin based composite	$290
D6210	Pontic – cast high noble metal	$290
D6211	Pontic – cast predominantly base metal	$290
D6212	Pontic – cast noble metal	$290
D6214	Pontic – titanium	$290
D6240	Pontic – porcelain fused to high noble metal	$290
D6241	Pontic – porcelain fused to predominantly base metal	$290
D6242	Pontic – porcelain fused to noble metal	$290
D6245	Pontic – porcelain/ceramic	$310
D6250	Pontic – resin with high noble metal	$290
D6251	Pontic – resin with predominantly base metal	$290
D6252	Pontic – resin with noble metal	$290
D6253	Provisional pontic – further treatment or completion of diagnosis necessary prior to final impression	$85
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$120
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$120
D6600	Inlay – porcelain/ceramic, two surfaces	$290
D6601	Inlay – porcelain/ceramic, three or more surfaces	$290
D6602	Inlay – cast high noble metal, two surfaces	$290
D6603	Inlay – cast high noble metal, three or more surfaces	$290
D6604	Inlay – cast predominantly base metal, two surfaces	$290
D6605	Inlay – cast predominantly base metal, three or more surfaces	$290
D6606	Inlay – cast noble metal, two surfaces	$290
D6607	Inlay – cast noble metal, three or more surfaces	$290
D6608	Onlay – porcelain/ceramic, two surfaces	$290
D6609	Onlay – porcelain/ceramic, three or more surfaces	$290
D6610	Onlay – cast high noble metal, two surfaces	$290
D6611	Onlay – cast high noble metal, three or more surfaces	$290
D6612	Onlay – cast predominantly base metal, two surfaces	$290
D6613	Onlay – cast predominantly base metal, three or more surfaces	$290

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D6614	Onlay – cast noble metal, two surfaces	$290
D6615	Onlay – cast noble metal, three or more surfaces	$290
D6624	Inlay – titanium	$290
D6634	Onlay – titanium	$290
D6710	Crown – indirect resin based composite	$290
D6720	Crown – resin with high noble metal	$290
D6721	Crown – resin with predominantly base metal	$290
D6722	Crown – resin with noble metal	$290
D6740	Crown – porcelain/ceramic	$290
D6750	Crown – porcelain fused to high noble metal	$290
D6751	Crown – porcelain fused to predominantly base metal	$290
D6752	Crown – porcelain fused to noble metal	$290
D6780	Crown – ¾ cast high noble metal	$290
D6781	Crown – ¾ cast predominantly base metal	$290
D6782	Crown – ¾ cast noble metal	$290
D6783	Crown – ¾ porcelain/ceramic	$290
D6790	Crown – full cast high noble metal	$290
D6791	Crown – full cast predominantly base metal	$290
D6792	Crown – full cast noble metal	$290
D6793	Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression	$85
D6794	Crown – titanium	$290
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
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	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$50
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partially bony	$65
D7240	Removal of impacted tooth – completely bony	$135
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40
D7251	Coronectomy – intentional partial tooth removal	$135
D7260	Oroantral fistula closure	$270
D7261	Primary closure of a sinus perforation	$275

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80
D7280	Surgical access of an unerupted tooth	$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue – hard (bone, tooth)	$150
D7286	Biopsy of oral tissue – soft	$60
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy – transepithelial sample collection	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40
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	$190
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$65
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	Surgical 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)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$35
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$505
D7910	Suture of recent small wounds up to 5 cm	$25
D7921	Collection and application of autologous blood concentrate product	$95
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	$600
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$825
D7952	Sinus augmentation via a vertical approach	$825
D7953	Bone replacement graft for ridge preservation – per site	$100
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure	$90

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	not incidental to another procedure	
D7963	Frenuloplasty	$90
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.	
•	Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances.	
D8010	Limited orthodontic treatment of the primary dentition	$1,095
D8020	Limited orthodontic treatment of the transitional dentition	$1,095
D8030	Limited orthodontic treatment of the adolescent dentition	$1,095
D8040	Limited orthodontic treatment of the adult dentition	$1,095
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,095
D8660	Pre-orthodontic treatment visit	$35
D8670	Periodic orthodontic treatment visit (as part of contract)	$35
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$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	$10
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
D9220	Deep sedation/general anesthesia – first 30 minutes	$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$150
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$45
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	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D9440	Office visit – after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9930	Treatment of complication (post-surgical) – unusual circumstances, by report	$0
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment – limited	$30
D9952	Occlusal adjustment – complete	$100

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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 are 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.

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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

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.

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 policyholder; You or Your Dependent had Orthodontic coverage under the policyholder'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 or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.

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

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;

DENTAL BENEFITS: EXCLUSIONS

- 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.