SafeGuard SCHEDULE OF BENEFITS

Direct Referral Dental Plan*

SG100A

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations.

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

* Prior authorization from SafeGuard is required for referrals to participating orthodontists and pediatric specialists. Your selected general dentist will submit all required documentation to SafeGuard and SafeGuard will advise you of the name, address and telephone number of a SafeGuard contracted orthodontist or pediatric specialist in your area.

Benefits provided by SafeGuard Health Plans, Inc.

D0120	tic Treatment Periodic oral evaluation – established patient Limited oral evaluation – problem focused	\$O
	Limited oral evaluation – problem focused	
D0140		* *
D0140		\$0
D0145	Oral evaluation for a patient under three years of age and counseling	ng
	with primary caregiver	\$0
D0150	Comprehensive oral evaluation – new or established patient	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	nt \$0
9491	Office visit - per visit (including all fees for sterilization and/	
	or infection control)	\$0
Radiogr	aphs/Diagnostic Imaging (X-rays)	
-	Intraoral – complete series (including bitewings)	\$0
D0220	Intraoral – periapical first film	\$0
	Intraoral – periapical each additional film	\$0
D0240	Intraoral – occlusal film	\$0
D0250	Extraoral – first film	\$0
D0260	Extraoral – each additional film	\$0
D0270	Bitewing – single film	\$0
D0272	Bitewings – two films	\$0
D0273	Bitewings – three films	\$0
D0274	Bitewings – four films	\$0
D0330	Panoramic film	\$0
D0350	Oral/facial photographic images	\$0
Tests a	nd Examinations	
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0

Co-payment Code Service

Droventive Conviers

Preventive Services					
Procedu	Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.				
D1110	Prophylaxis – adult*	\$0			
D1120	Prophylaxis – child*	\$0			
D1203	Topical application of fluoride (prophylaxis not included) - child*	\$0			
D1204	Topical application of fluoride (prophylaxis not included) – adult*	\$0			
D1206	Topical fluoride varnish; therapeutic application for moderate to high				
	caries risk patients*	\$0			
D1330	Oral hygiene instructions	\$0			
D1351	Sealant – per tooth	\$5			
D1510	Space maintainer – fixed – unilateral	\$30			
D1515	Space maintainer – fixed – bilateral	\$30			
D1520	Space maintainer – removable – unilateral	\$30			
	Space maintainer – removable – bilateral	\$30			
	Recementation of space maintainer	\$5			
D1555	Removal of fixed space maintainer	\$5			
	tive Treatment				
	Amalgam – one surface, primary or permanent	\$0			
	Amalgam – two surfaces, primary or permanent	\$0			
	Amalgam – three surfaces, primary or permanent	\$0			
	Amalgam – four or more surfaces, primary or permanent	\$0			
	Resin-based composite – one surface, anterior	\$0			
	Resin-based composite – two surfaces, anterior	\$0			
	Resin-based composite – three surfaces, anterior	\$0			
D2335	Resin-based composite – four or more surfaces or involving incisal	* •			
	angle (anterior)	\$0			
	Resin-based composite crown, anterior	\$30			
	Resin-based composite – one surface, posterior	\$65			
	Resin-based composite – two surfaces, posterior	\$75			
	Resin-based composite – three surfaces, posterior	\$80			
D2394	Resin-based composite – four or more surfaces, posterior	\$80			

Crowns · Replacement limit 1 every 5 years. · An additional charge will be applied for any procedure using noble or high noble metal. · Cases involving 7 or more crowns in the same treatment plan require additional \$125 member fee per unit in addition to co-pay. • \$75 fee per crown unit above co-pay for porcelain on molars. **D2510** Inlay – metallic – one surface \$100 D2520 Inlay - metallic - two surfaces \$100 D2530 Inlay - metallic - three or more surfaces \$100 **D2543** Onlay – metallic – three surfaces \$100 D2544 Onlay - metallic - four or more surfaces \$100 **D2740** Crown – porcelain/ceramic substrate \$225 D2750 Crown - porcelain fused to high noble metal \$100 D2751 Crown - porcelain fused to predominantly base metal \$100 **D2752** Crown – porcelain fused to noble metal \$100 D2780 Crown - 3/4 cast high noble metal \$100 **D2781** Crown – ³/₄ cast predominantly base metal \$100 **D2782** Crown – ³/₄ cast noble metal \$100 **D2790** Crown – full cast high noble metal \$100 D2791 Crown - full cast predominantly base metal \$100 **D2792** Crown – full cast noble metal \$100

SG100A-SOB

Code	Service Co-p	ayment
D2794	Crown – titanium	\$100
	Recement inlay, onlay, or partial coverage restoration	\$0
	Recement cast or prefabricated post and core	\$0
	Recement crown	\$0
	Prefabricated stainless steel crown - primary tooth	\$0
	Prefabricated stainless steel crown - permanent tooth	\$0
	Sedative filling	\$0
	Core buildup, including any pins	\$15
	Pin retention – per tooth, in addition to restoration	\$10
	Post and core in addition to crown, indirectly fabricated	\$40
	Prefabricated post and core in addition to crown	\$40
	Post removal (not in conjunction with endodontic therapy)	\$10
D2970	Temporary crown (fractured tooth)	\$0
Endodo	ntics	
All proc	edures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	\$0
	Pulp cap – indirect (excluding final restoration)	\$0
03220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp	
03230	coronal to the dentinocemental junction and application of medicament Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding	\$0
	final restoration)	\$5
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding	
	final restoration)	\$10
	Anterior (excluding final restoration)	\$70
	Bicuspid (excluding final restoration)	\$80
	Molar (excluding final restoration)	\$200
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured	
	tooth	\$70
	Retreatment of previous root canal therapy – anterior	\$80
	Retreatment of previous root canal therapy - bicuspid	\$100
	Retreatment of previous root canal therapy – molar	\$210
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair	
	of perforations, root resorption, etc.)	\$65
D3352	Apexification/recalcification – interim medication replacement (apical	
	closure/calcific repair of perforations, root resorption, etc.)	\$65
D3353	Apexification/recalcification - final visit (includes completed root canal	
	therapy - apical closure/calcific repair of perforations, root resorption, etc	
	Apicoectomy/periradicular surgery – anterior	\$180
	Apicoectomy/periradicular surgery – bicuspid (first root)	\$180
	Apicoectomy/periradicular surgery – molar (first root)	\$180
	Apicoectomy/periradicular surgery (each additional root)	\$180
	Retrograde filling – per root	\$180
D3450	Root amputation – per root	\$95
03920	Hemisection (including any root removal), not including root canal therap	y \$90
Periodo		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or	
	bounded teeth spaces per quadrant	\$50
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or	
	bounded teeth spaces per quadrant	\$38
D4240	Gingival flap procedure, including root planing - four or more	
	contiguous teeth or bounded teeth spaces per quadrant	\$300
D4241	Gingival flap procedure, including root planing - one to three	
	contiguous teeth or bounded teeth spaces per quadrant	\$225
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	Service Co	p-payment
D4249	Clinical crown lengthening – hard tissue	\$125
	Osseous surgery (including flap entry and closure) – four or more	
	contiguous teeth or bounded teeth spaces per quadrant	\$300
D4261	Osseous surgery (including flap entry and closure) - one to three	
	contiguous teeth or bounded teeth spaces per quadrant	\$225
D4270	Pedicle soft tissue graft procedure	\$250
D4271	Free soft tissue graft procedure (including donor site surgery)	\$250
D4273	Subepithelial connective tissue graft procedures, per tooth	\$75
D4274	Distal or proximal wedge procedure (when not performed in conjunctio	n
	with surgical procedures in the same anatomical area)	\$70
	Periodontal scaling and root planing - four or more teeth per quadran	
	Periodontal scaling and root planing - one to three teeth per quadran	t \$19
D4355	Full mouth debridement to enable comprehensive evaluation and	
	diagnosis	\$25
D4381	Localized delivery of antimicrobial agents via a controlled release	* • • •
	vehicle into diseased crevicular tissue, per tooth, by report	\$60
D4910	Periodontal maintenance (2 in a 12 month period)	\$25
Remova	ble Prosthodontics	
• Repla	cement 1 every 5 years.	
 Reline 	es are limited to 1 every 24 months.	
 Includ 	les up to 3 adjustments within 6 months of delivery.	
	Complete denture – maxillary	\$125
	Complete denture – mandibular	\$125
	Immediate denture – maxillary	\$125
	Immediate denture – mandibular	\$125
D5211	Maxillary partial denture - resin base (including any conventional	
	clasps, rests and teeth)	\$110
D5212	Mandibular partial denture – resin base (including any conventional	* 4 4 0
	clasps, rests and teeth)	\$110
D5213	Maxillary partial denture – cast metal framework with resin denture	#450
	bases (including any conventional clasps, rests and teeth)	\$150
D5214	Mandibular partial denture – cast metal framework with resin denture	
DE440	bases (including any conventional clasps, rests and teeth)	\$150
	Adjust complete denture – maxillary	\$0 \$0
	Adjust complete denture – mandibular Adjust partial denture – maxillary	\$0 \$0
	Adjust partial denture – maximary Adjust partial denture – mandibular	\$0 \$0
	Repair broken complete denture base	\$15
	Replace missing or broken teeth – complete denture (each tooth)	\$15
	Repair resin denture base	\$15
	Repair cast framework	\$15
	Repair or replace broken clasp	\$15
	Replace broken teeth – per tooth	\$15
	Add tooth to existing partial denture	\$15
	Add clasp to existing partial denture	\$15
	Rebase complete maxillary denture	\$50
	Rebase complete mandibular denture	\$50
	Rebase maxillary partial denture	\$50
	Rebase mandibular partial denture	\$50
	Reline complete maxillary denture (chairside)	\$40
	Reline complete mandibular denture (chairside)	\$40
	Reline maxillary partial denture (chairside)	\$40
D57/11	Reline mandibular partial denture (chairside)	\$40
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Code	Service	Co-payment
D5750	Reline complete maxillary denture (laboratory)	\$40
D5751	Reline complete mandibular denture (laboratory)	\$40
D5760	Reline maxillary partial denture (laboratory)	\$40
D5761	Reline mandibular partial denture (laboratory)	\$40
D5820	Interim partial denture (maxillary)	\$40
D5821	Interim partial denture (mandibular)	\$40
D5850	Tissue conditioning, maxillary	\$10
D5851	Tissue conditioning, mandibular	\$10

Crowns/Fixed Bridges - Per Unit

Replacement limit 1 every 5 years.
An additional charge will be applied for any procedure using noble or high noble metal.
Cases involving 7 or more crowns and/or fixed bridge units in the same treatment plan require additional \$125 member fee per unit in addition to co-pay.

• \$75 fee per crown/bridge unit above co-pay for porcelain on molars.

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D6210	Pontic – cast high noble metal	\$100
D6211	Pontic – cast predominantly base metal	\$100
D6212	Pontic – cast noble metal	\$100
D6214	Pontic – titanium	\$100
D6240	Pontic – porcelain fused to high noble metal	\$100
D6241	Pontic – porcelain fused to predominantly base metal	\$100
D6242	Pontic – porcelain fused to noble metal	\$100
D6750	Crown – porcelain fused to high noble metal	\$100
D6751	Crown – porcelain fused to predominantly base metal	\$100
D6752	Crown – porcelain fused to noble metal	\$100
D6780	Crown – ¾ cast high noble metal	\$100
D6781	Crown – ³ / ₄ cast predominantly base metal	\$100
D6782	Crown – ¾ cast noble metal	\$100
D6790	Crown – full cast high noble metal	\$100
D6791	Crown – full cast predominantly base metal	\$100
D6792	Crown – full cast noble metal	\$100
D6794	Crown – titanium	\$100
D6930	Recement fixed partial denture	\$0
D6970	Post and core in addition to fixed partial denture retainer, indirectly	
	fabricated	\$40
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$40
D6973	Core build up for retainer, including any pins	\$15

Oral Surgery

 Includes routine post operative visits/treatment.
 Surginal removal of impacted teeth not covered in . othology (dio

	moradoo roadin	o poor operation		110	
•	Surgical remova	al of impacted	teeth not covere	ed unless patholo	gy (disease) exists.
	0			c	

• Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps		
	removal)	\$0	
D7210	10 Surgical removal of erupted tooth requiring elevation of mucoperiosteal		
	flap and removal of bone and/or section of tooth	\$20	
D7220	Removal of impacted tooth – soft tissue	\$50	
D7230	Removal of impacted tooth - partially bony	\$100	
D7240	Removal of impacted tooth – completely bony	\$125	
D7241	Removal of impacted tooth - completely bony, with unusual surgical		
	complications	\$130	
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$50	
D7270	D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or		
	displaced tooth	\$110	
D7280	Surgical access of an unerupted tooth	\$175	
SG100A-SC	B Customer Service (800) 880-1800	3/07	

D7286 Biopsy of oral tissue – soft \$(0) D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant \$(0) D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$(0) D7320 Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant \$(0) D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$(0) D760 Frenulectomy (frenectomy or frenotomy) – separate procedure \$(1) D7961 Frenulectomy (frenectomy or frenotomy) – separate procedure \$(2) D7963 Frenuloplasty \$(2) D7964 Frenuloplasty \$(2) D7965 Frenuloplasty \$(2) D7964 Frenuloplasty \$(2) D8020 Limited orthodontic treatment of the transitional dentition \$722 D8020 Limited orthodontic treatment of the adolescent dentition \$725 D8030 Limited orthodontic treatment of the adolescent dentition \$1,456 D8040 Comprehensive orthodontic treatment of the adolescent dentition \$1,456 D8050 Comprehensive orthodontic	7286 Biopsy of oral tissue – soft \$C 7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant \$C 7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$C 7320 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$C 7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$C 7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant \$C 7960 Frenulectomy (frenectomy or frenotomy) – separate procedure \$C 7971 Excision of pericoronal gingiva \$40 *thodontics * \$C 8030 Limited orthodontic treatment of the transitional dentition \$725 8030 Limited orthodontic treatment of the adult dentition \$1,450 8040 Limited orthodontic treatment of the adult dentition \$1,450 8050 Comprehensive orthodontic treatment of the adult dentition \$1,450 8060 Pre-orthodontic treatment visit \$C 8680 Orthodontic reatment visit \$C 8680	Code	Service	Co-payment
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Current Dental Terminology © American Dental Association

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam:	A silver filling
Anterior:	Teeth that are in the front of the mouth
Bicuspid:	Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
Bridge:	A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
Crown:	A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.
Endodontics:	Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
Oral Surgery:	Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
Orthodontics:	Braces and other procedures to straighten the teeth.
Periodontics:	Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
Posterior:	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth:	The first set of teeth ("baby" teeth).
Prophylaxis:	Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics:	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant:	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite:	Tooth-colored (white) fillings

Exclusions and Limitations

Exclusions

- 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. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
- 3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
- 4. Any dental services, or appliances which are determined to be not reasonable and/ or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist.
- 5. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
- 6. Orthognathic surgery.
- 7. General anesthesia or intravenous sedation.
- 8. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
- 9. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
- 10. Treatment of malignancies, cysts, or neoplasms.
- 11. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
- 12. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
- 13. Precision attachments.
- 14. 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.
- 15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- 16. Services considered unnecessary or experimental in nature.
- 17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
- 18. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Limitations

- 1. Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.
- 2. An additional charge will be applied for any procedure using noble or high noble metal.
- 3. Relines are limited to one every twenty four (24) months.
- 4. Full-mouth X-rays: Once every three (3) years, unless medically necessary.
- 5. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.

Exclusions and Limitations

- 6. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.
- 7. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
- 8. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
- 9. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional \$125 co-payment per unit in addition to co-payment for each crown/bridge unit.
- 10. There is a \$75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
- 11. Surgical removal of wisdom teeth/third molar for orthodontic reasons <u>only</u> is not a covered benefit.
- 12. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
- 13. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.
- 14. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions and Limitations

- 1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist in order for the co-payments listed in the Schedule of Benefits to apply.
- 2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of \$25 dollars.
- 3. The following are not included as orthodontic benefits:
 - A. Repair or replacement of lost or broken appliances;
 - B. Retreatment of orthodontic cases;
 - C. Treatment in progress at inception of eligibility;
 - D. Interceptive orthodontics;
 - E. Changes in treatment necessitated by an accident;
 - F. Treatment involving:
 - 1.) Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
 - 2.) Hormonal imbalances or other factors affecting growth or developmental abnormalities;
 - 3.) Treatment related to temporomandibular joint disorders;
 - Lingually placed direct bonded appliances and arch wires ("invisible braces"); and
- 4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.