SafeGuard SCHEDULE OF BENEFITS

SELF-REFERRAL DENTAL PLAN **Premier Choice**

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; please review them before your first dental appointment. It is important to discuss all recommended procedures with your provider prior to treatment.

The following co-payments apply only when services are performed by your selected SafeGuard general dentist. If you choose to receive services from a SafeGuard contracted specialty care provider (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 75% of that provider's usual fee for those services. A list of these contracted dentists may be found through SafeGuard's online directory at www.safeguard.net.

In addition, non-listed services are available with your SafeGuard selected general dentist or specialty care dentist at 75% of their usual and customary fees.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention. You may be charged a co-payment if you do not give the dental office at least 24 hours notice.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation - problem focused	$5
D0145	Oral evaluation for a patient under three years of age and counseling with primary care giver	$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 postoperative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
9491	Office visit – per visit (including all fees for sterilization and/ or infection control)	$5
Radiographs/Diagnostic Imaging (X-rays)		
D0210	X-rays intraoral - complete series - including bitewings (once every 3 years)	$0
D0220	X-rays intraoral - periapical - first film	$0
D0230	X-rays intraoral - periapical - each additional film	$0
D0240	X-rays intraoral - occlusal film	$0
D0250	X-rays extraoral - first film	$0
D0260	X-rays extraoral - each additional film	$0
D0270	X-rays bitewing - single film	$0
D0272	X-rays bitewings - two films	$0
D0273	X-rays bitewings - three films	$0
D0274	X-rays bitewings - four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	X-rays panoramic film	$0
D0350	Oral/facial photographic images	$0

Code	Service	Co-payment
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 lesions; not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
Preventive Services		
Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.		
D1110	Prophylaxis - adult	$0
D1110	Additional – adult prophylaxis (maximum of two additional per year)	$35
D1120	Prophylaxis - child	$0
D1120	Additional – child prophylaxis (maximum of two additional per year)	$25
D1203	Topical application of fluoride (excluding prophylaxis) - child	$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$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
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$65
D1515	Space maintainer - fixed - bilateral	$65
D1520	Space maintainer - removable - unilateral	$80
D1525	Space maintainer - removable - bilateral	$80
D1550	Recementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15
Restorative Treatment		
D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$25
D2331	Resin-based composite - two surfaces, anterior	$35
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	$70
D2390	Resin-based composite crown, anterior	$60
D2391	Resin-based composite, one surface, posterior	$65
D2392	Resin-based composite, two surfaces, posterior	$75
D2393	Resin-based composite, three surfaces, posterior	$85
D2394	Resin-based composite, four or more surfaces, posterior	$85

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 crown/bridge unit in addition to regular co-payments for porcelain on molars.*
- *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.*

Code	Service	Co-payment
D2510	Inlay - metallic - one surface	$225
D2520	Inlay - metallic - two surfaces	$235

Code	Service	Co-payment
D2530	Inlay - metallic - three or more surfaces	$245
D2543	Onlay - metallic - three surfaces	$260
D2544	Onlay - metallic - four or more surfaces	$300
D2610	Inlay – porcelain/ceramic – one surface	$245
D2620	Inlay – porcelain/ceramic – two surfaces	$245
D2630	Inlay – porcelain/ceramic – three or more surfaces	$245
D2740	Crown - porcelain/ceramic substrate	$245
D2750	Crown - porcelain fused to high noble metal	$245
D2751	Crown - porcelain fused to predominantly base metal	$245
D2752	Crown - porcelain fused to noble metal	$245
D2780	Crown - 3/4 cast high noble metal	$245
D2781	Crown - 3/4 cast predominantly base metal	$245
D2782	Crown - 3/4 cast noble metal	$245
D2790	Crown - full cast high noble metal	$245
D2791	Crown - full cast predominantly base metal	$245
D2792	Crown - full cast noble metal	$245
D2794	Crown – titanium	$245
D2799	Provisional crown	$0
D2910	Recement inlay	$15
D2915	Recement cast or prefabricated post and core	$15
D2920	Recement crown	$15
D2930	Prefabricated stainless steel crown - primary tooth	$40
D2931	Prefabricated stainless steel crown - permanent tooth	$40
D2940	Sedative filling	$10
D2950	Core build up, including any pins	$70
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Post and core in addition to crown, indirectly fabricated	$85
D2954	Prefabricated post and core in addition to crown	$75
D2955	Post removal (not in conjunction with endodontic therapy)	$40
D2960	Labial veneer (resin laminate) – chairside	$300
D2961	Labial veneer (resin laminate) – laboratory	$380
D2962	Labial veneer (porcelain laminate) – laboratory	$380
D2970	Temporary crown (fractured tooth)	$0
D2980	Crown repair, by report	$0

Endodontics

All procedures exclude final restoration

Code	Service	Co-payment
D3110	Pulp cap - direct	$10
D3120	Pulp cap - indirect	$10
D3220	Therapeutic pulpotomy	$30
D3221	Pulpal debridement, primary and permanent teeth	$55
D3230	Pulpal therapy with resorbable filling - primary anterior tooth	$40
D3240	Pulpal therapy with resorbable filling - primary posterior tooth	$40
D3310	Root canal - anterior - per tooth	$110
D3320	Root canal - bicuspid - per tooth	$185
D3330	Root canal - molar - per tooth	$265
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3346	Retreatment of root canal - anterior, per tooth	$180
D3347	Retreatment of root canal - bicuspid, per tooth	$280
D3348	Retreatment of root canal - molar, per tooth	$325
D3351	Apexification/recalcification - initial visit	$90
D3352	Apexification/recalcification - interim visit	$90
D3353	Apexification/recalcification - final visit	$90

Code	Service	Co-payment
D3410	Apicoectomy/periradicular surgery - anterior	$100
D3421	Apicoectomy/periradicular surgery - bicuspid - 1st root	$100
D3425	Apicoectomy/periradicular surgery - molar, 1st root	$100
D3426	Apicoectomy/periradicular surgery - each additional root	$60
D3430	Retrograde filling - per root	$60
D3450	Root amputation - per root	$95
D3920	Hemisection - including root removal (excluding root canal therapy)	$90

Periodontics

Code	Service	Co-payment
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$110
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$83
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	$113
D4249	Clinical crown lengthening - hard tissue	$150
D4260	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 teeth, per quadrant	$225
D4270	Pedicle soft tissue graft procedure	$245
D4271	Free soft tissue graft procedure (including donor site surgery)	$245
D4273	Subepithelial connective tissue graft procedure	$75
D4274	Distal or proximal wedge procedure - separate procedure	$100
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$95
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces - 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 a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$65
D4910	Periodontal maintenance procedures - following active surgery (2 in a 12 month period)	$40
D4910	Additional periodontal maintenance procedure (beyond 2 per 12 months)	$55
D4999	Periodontal charting for planning treatment of periodontal disease	$0
D4999	Periodontal hygiene instruction	$0

Removable Prosthodontics

- *Replacement limit 1 every 5 years.*
- *Relines are limited to 1 every 12 months.*
- *Includes up to 3 adjustments within 6 months of delivery.*

Code	Service	Co-payment
D5110	Complete upper denture	$325
D5120	Complete lower denture	$325
D5130	Immediate upper denture	$350
D5140	Immediate lower denture	$350
D5211	Upper partial - resin base (including clasps, rests and teeth)	$400
D5212	Lower partial - resin base (including clasps, rests and teeth)	$400
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth)	$425
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth)	$425

Code	Service	Co-payment
D5410	Adjust complete denture - upper	$10
D5411	Adjust complete denture - lower	$10
D5421	Adjust partial denture - upper	$10
D5422	Adjust partial denture - lower	$10
D5510	Repair broken complete denture base	$35
D5520	Replace missing or broken teeth	$35
D5610	Repair resin denture base	$35
D5620	Repair cast framework	$35
D5630	Repair or replace broken clasp	$35
D5640	Replace broken teeth - per tooth	$35
D5650	Add tooth to existing partial denture	$35
D5660	Add clasp to existing partial denture	$35
D5710	Rebase complete upper denture	$75
D5711	Rebase complete lower denture	$75
D5720	Rebase upper partial denture	$75
D5721	Rebase lower partial denture	$75
D5730	Reline complete upper denture (chairside)	$65
D5731	Reline complete lower denture (chairside)	$65
D5740	Reline upper partial denture (chairside)	$65
D5741	Reline lower partial denture (chairside)	$65
D5750	Reline complete upper denture (laboratory)	$85
D5751	Reline complete lower denture (laboratory)	$85
D5760	Reline upper partial denture (laboratory)	$85
D5761	Reline lower partial denture (laboratory)	$85
D5820	Interim partial denture - upper	$175
D5821	Interim partial denture - lower	$175
D5850	Tissue conditioning - upper	$20
D5851	Tissue conditioning - lower	$20

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 crown/bridge unit in addition to regular co-payments for porcelain on molars.*
- *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.*

Code	Service	Co-payment
D6210	Pontic - cast high noble metal	$245
D6211	Pontic - cast predominantly base metal	$245
D6212	Pontic - cast noble metal	$245
D6214	Pontic – titanium	$245
D6240	Pontic - porcelain fused to high noble metal	$245
D6241	Pontic - porcelain fused to predominantly base metal	$245
D6242	Pontic - porcelain fused to noble metal	$245
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$245
D6721	Crown – resin with predominantly base metal	$245
D6750	Crown - porcelain fused to high noble metal	$245
D6751	Crown - porcelain fused to predominantly base metal	$245
D6752	Crown - porcelain fused to noble metal	$245
D6780	Crown - 3/4 cast high noble metal	$245
D6781	Crown - 3/4 cast predominantly base metal	$245
D6782	Crown - 3/4 cast noble metal	$245
D6790	Crown - full cast high noble metal	$245
D6791	Crown - full cast predominantly base metal	$245
D6792	Crown - full cast noble metal	$245

Code	Service	Co-payment
D6794	Crown – titanium	$245
D6930	Recement bridge	$15
D6970	Post and core in addition to fixed partial denture retainer, Indirectly fabricated	$85
D6972	Prefabricated post and core in addition to bridge retainer	$75
D6973	Core build up for retainer, including any pins	$70
D6980	Fixed partial denture repair, by report	$45

Oral Surgery

- *Includes routine post operative visits/treatment.*
- *The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.*

Code	Service	Co-payment
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	$30
D7220	Extraction - removal of impacted tooth - soft tissue	$50
D7230	Extraction - removal of impacted tooth - partially bony	$65
D7240	Extraction - removal of impacted tooth - completely bony	$80
D7241	Extraction - removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical extraction - removal of residual tooth roots	$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Surgical exposure of impacted unerupted tooth for orthodontic reasons	$200
D7285	Biopsy of oral tissue - hard	$150
D7286	Biopsy of oral tissue - soft	$150
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy – transepithelial sample collection	$50
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	$15
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$60
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7510	Incision and drainage of abscess – intracoronal soft tissue	$35
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$50
D7963	Frenuloplasty	$50
D7971	Excision of pericoronal gingiva	$40

Orthodontics

Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.

Code	Service	Co-payment
D8010	Limited orthodontic treatment of the primary dentition	75% of U&C
D8020	Limited orthodontic treatment of the transitional dentition	75% of U&C
D8030	Limited orthodontic treatment of the adolescent dentition	75% of U&C
D8040	Limited orthodontic treatment of the adult dentition	75% of U&C
D8050	Interceptive orthodontic treatment of the primary dentition	75% of U&C

Code	Service	Co-payment
D8060	Interceptive orthodontic treatment of the transitional dentition	75% of U&C
D8070	Comprehensive orthodontic treatment of the transitional dentition	75% of U&C
D8080	Comprehensive orthodontic treatment of the adolescent dentition	75% of U&C
D8090	Comprehensive orthodontic treatment of the adult dentition	75% of U&C
D8210	Removable appliance therapy	75% of U&C
D8220	Fixed appliance therapy	75% of U&C
D8660	Consultation	75% of U&C
D8670	Periodic orthodontic treatment visit (as part of contract)	75% of U&C
D8680	Retention phase (including fee for fixed/removable retainers and monthly visits for 24 months)	75% of U&C
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	75% of U&C
D8999	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	75% of U&C
D8999	Orthodontic visits beyond 24 months of active treatment or retention	75% of U&C

Adjunctive General Services

Code	Service	Co-payment
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia – first 30 minutes	$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Analgesia, Anxiolysis, inhalation of nitrous oxide	$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	$5
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9630	Medicinal application/irrigation per visit	$15
D9940	Occlusal guard, by report	$85
D9951	Occlusal adjustment - limited	$30
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching – per arch	$125
D9999	Broken appointment (less than 24-hour notice)	Not to exceed $25

VISION PLAN

This vision plan includes in- and out-of-network benefits as listed below; if you visit a network provider, you will receive the maximum benefit. If you choose to see an out-of-network provider, you will be responsible for the co-payment amount listed below. If you choose to see an out-of–network provider, you will be reimbursed the Maximum Benefit Allowance set forth below.

Frequency (months)	**Exam**
	12

	In-Network Coverage (Using a Network Provider)	**Out-of-Network Coverage (Using a Non-Network Provider)**
Exam	**Your Co-payment** $20	**Your Maximum Benefit Allowance** $35 You are responsible for the provider's usual charge; reimbursement for the amount listed will be paid upon receipt of your claim.

Please refer to your Evidence of Coverage for details on the process and administration of your coverage.

Please note:
You are entitled to receive a discount on the following services if they are received by an in-network provider:

Frames: 20% on the participating provider's usual and customary retail fees charged to non-members

Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members

Elective Contact Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members (excluding disposable and frequent replacement contact lenses)

All other non-covered eyewear and options (excluding disposable and frequent replacement contact lenses): 20% on the participating provider's usual and customary retail fees charged to non-members

All other non-covered professional services: 10% on the participating provider's usual and customary retail fees charged to non-members

Benefits provided by SafeGuard Health Plans, Inc.

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

Limitations

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to 2 per 12 months. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble or high noble metal.
2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
3. Cases involving seven (7) or more crowns 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/bridge unit.
4. There is a $75 co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) month.
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 functioning tooth. 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 SafeGuard General Dentist.
3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

General Exclusions

1. Services performed by any dentist not contracted with SafeGuard, without prior approval by SafeGuard (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
3. 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.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary 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 specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the Armed Forces of any country or international authority.
12. Dental services considered experimental in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

Orthodontic Exclusions & Limitations

Your co-payments will be 75% of your selected SafeGuard general or specialty care dentist's usual and customary fees. If your general dentist does not provide orthodontic care, you may receive care from a SafeGuard contracted dentist whose practice is limited to orthodontic care. A listing of contracted dentists whose practice is limited to orthodontic care can be found online at www.safeguard.net, or you may call Customer Service.

If you terminate coverage from the SafeGuard Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a SafeGuard selected general dentist or SafeGuard contracted orthodontist in order for the co-payments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-visit charge of 75% of your SafeGuard selected general dentist's or Safeguard contracted orthodontist's usual and customary fees.
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 involving:
     - i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
     - ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
     - iii. Treatment related to temporomandibular joint disorders;
     - iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

VISION EXCLUSIONS

The following are excluded from coverage:

1. Charges for procedures, services or materials that are not included as covered charges; however, contracted vision providers have agreed to provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
2. Any portion of a charge in excess of the allowance or reimbursement indicated in the Summary of Benefits.
3. Expenses for any non-covered lens materials, including but not limited to the following: coated, dyed, glass lens or laminated lenses, progressive, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromic/photosensitive; however, contracted vision providers have agreed to provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
4. Orthoptics, vision training and any associated supplemental testing.
5. Medical or surgical treatment of the eye.
6. Prescription or non-prescription medications.
7. Any eye examination or any corrective eyewear required as a condition of employment.
8. Services or materials that are experimental, cosmetic or not medically necessary.
9. Any service or material not prescribed or furnished by an ophthalmologist, optometrist or registered dispensing optician.
10. Services and materials furnished in conjunction with excluded services and materials.
11. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
12. Services and materials that a covered person received during a service interval under any other plan offered by the Company or one of the Company's affiliates.
13. Charges incurred before a covered person's effective date of coverage under the Policy or after such coverage terminates.
14. Services or materials received as a result of disease, defect, or injury due to taking part in a riot or insurrection, or committing or attempting to commit a felony.
15. Services and materials obtained while outside the United States, except for emergency vision care.
16. Services or materials resulting from or in the course of a covered person's regular occupation for pay or profit for which the covered person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
17. Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States;
18. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

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