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 these 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation – established patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>$5</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary care giver</td>
<td>$0</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation – problem focused, by report</td>
<td>$0</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation – limited, problem focused (established patient; not postoperative visit)</td>
<td>$0</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient Office visit – per visit (including all fees for sterilization and/or infection control)</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Radiographs/Diagnostic Imaging (X-rays)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>X-rays intraoral - complete series - including bitewings (once every 3 years)</td>
<td>$0</td>
</tr>
<tr>
<td>D0220</td>
<td>X-rays intraoral - periapical - first film</td>
<td>$0</td>
</tr>
<tr>
<td>D0230</td>
<td>X-rays intraoral - periapical - each additional film</td>
<td>$0</td>
</tr>
<tr>
<td>D0240</td>
<td>X-rays intraoral - occlusal film</td>
<td>$0</td>
</tr>
<tr>
<td>D0250</td>
<td>X-rays extraoral - first film</td>
<td>$0</td>
</tr>
<tr>
<td>D0260</td>
<td>X-rays extraoral - each additional film</td>
<td>$0</td>
</tr>
<tr>
<td>D0270</td>
<td>X-rays bitewing - single film</td>
<td>$0</td>
</tr>
<tr>
<td>D0272</td>
<td>X-rays bitewings - two films</td>
<td>$0</td>
</tr>
<tr>
<td>D0273</td>
<td>X-rays bitewings - three films</td>
<td>$0</td>
</tr>
<tr>
<td>D0274</td>
<td>X-rays bitewings - four films</td>
<td>$0</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings – 7 to 8 films</td>
<td>$0</td>
</tr>
<tr>
<td>D0330</td>
<td>X-rays panoramic film</td>
<td>$0</td>
</tr>
<tr>
<td>D0350</td>
<td>Oral/facial photographic images</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Crown Co-payments**

- 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.
- 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 molar.

**Tests and Examinations**

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0415</td>
<td>Collection of microorganisms for culture and sensitivity</td>
<td>$0</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
<td>$0</td>
</tr>
<tr>
<td>D0431</td>
<td>Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant lesions; not to include cytology or biopsy procedures</td>
<td>$50</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>$0</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Preventive Services**

- Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.
- Additional – child prophylaxis (maximum of two additional per year)

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>$0</td>
</tr>
<tr>
<td>D1110</td>
<td>Additional – adult prophylaxis (maximum of two additional per year)</td>
<td>$35</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - child</td>
<td>$0</td>
</tr>
<tr>
<td>D1120</td>
<td>Additional – child prophylaxis (maximum of two additional per year)</td>
<td>$25</td>
</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (excluding prophylaxis) - child</td>
<td>$0</td>
</tr>
<tr>
<td>D1204</td>
<td>Topical application of fluoride (excluding prophylaxis) - adult</td>
<td>$0</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high carries risk patients</td>
<td>$0</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for control of dental disease</td>
<td>$0</td>
</tr>
<tr>
<td>D1320</td>
<td>Tobacco counseling for the control and prevention of oral disease</td>
<td>$0</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions</td>
<td>$0</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealing - per tooth</td>
<td>$5</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>$65</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>$65</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer - removable - unilateral</td>
<td>$80</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral</td>
<td>$80</td>
</tr>
<tr>
<td>D1550</td>
<td>Recementation of space maintainer</td>
<td>$15</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
<td>$15</td>
</tr>
</tbody>
</table>

**Restorative Treatment**

- Amalgam - one surface, primary or permanent
- Amalgam - two surfaces, primary or permanent
- Amalgam - three surfaces, primary or permanent
- Amalgam - four or more surfaces, primary or permanent
- Resin-based composite - one surface, anterior
- Resin-based composite - two surfaces, anterior
- Resin-based composite - three surfaces, anterior
- Resin-based composite - four or more surfaces or involving incisal angle, anterior
- Resin-based composite crown, anterior
- Resin-based composite, one surface, posterior
- Resin-based composite, two surfaces, posterior
- Resin-based composite, three surfaces, posterior
- Resin-based composite, four or more surfaces, posterior

**Crows**

- 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 molar.
- 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.
Crown - full cast noble metal $245
Crown - full cast predominantly base metal $245
Crown - full cast high noble metal $245

Crown - 3/4 cast noble metal $245
Crown - 3/4 cast predominantly base metal $245
Crown - 3/4 cast high noble metal $245

Crown - porcelain fused to noble metal $245
Crown - porcelain fused to predominantly base metal $245
Crown - porcelain fused to high noble metal $245

Crown – resin with predominantly base metal $245

Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment
· 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.

Crown – porcelain fused to high noble metal $245

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

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

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
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.

<table>
<thead>
<tr>
<th>Frequency (months)</th>
<th>Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In-Network Coverage (Using a Network Provider)</th>
<th>Out-of-Network Coverage (Using a Non-Network Provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam</strong></td>
<td><strong>Your Co-payment</strong></td>
</tr>
<tr>
<td>In-Network Coverage (Using a Network Provider)</td>
<td>$20</td>
</tr>
<tr>
<td>Out-of-Network Coverage (Using a Non-Network Provider)</td>
<td></td>
</tr>
</tbody>
</table>

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:** 20% 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, 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 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.

**Language Assistance**

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at (800) 800-1800.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al (800) 800-1800.

作為SafeGuard的會員，您有權獲得免費語言服務，包括口譯和筆譯。SafeGuard收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴SafeGuard，可通過電話或網站與SafeGuard聯絡，電話是(800) 880-1800。
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.