MetLife

SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan* 0374-DI

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each service. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. We have also added some dental terminology definitions to help you better understand your plan these can be found at the back of this Schedule.

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

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

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
D0180	Comprehensive periodontal evaluation - new or established patient	$0
•	Office visit – per visit (including all fees for sterilization and/or infection control	$5
	Radiographs / Diagnostic Imaging (X-rays)	$0
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
D0270	Bitewing – single radiographic image	$0
D0272	Bitewings – two radiographic images	$0
D0273	Bitewings – three radiographic images	$0
D0274	Bitewings – four radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	Oral/facial photographic image obtained intraorally or extraorally	$0
	Tests and Examinations	
D0460	Pulp vitality tests	$0
	Preventive Services	
	Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.	
D1110	Prophylaxis – adult*	$0
D1120	Prophylaxis – child*	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D1206	Topical application of fluoride varnish*	$0
D1208	Topical application of fluoride*	$0
D1330	Oral hygiene instructions	$0
D1510	Space maintainer – fixed – unilateral	$20
D1515	Space maintainer – fixed – bilateral	$20
D1520	Space maintainer – removable – unilateral	$20
D1525	Space maintainer – removable – bilateral	$20
D1555	Removal of fixed space maintainer	$5
	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	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$0
	Crowns	
•	*An additional charge will be applied for any procedure using noble or high noble metal.*	
•	*$75 fee per crown unit above co-pay for porcelain on molars.*	
D2740	Crown – porcelain/ceramic substrate	$85
D2750	Crown – porcelain fused to high noble metal	$85
D2751	Crown – porcelain fused to predominantly base metal	$85
D2752	Crown – porcelain fused to noble metal	$85
D2780	Crown – ¾ cast high noble metal	$85
D2781	Crown – ¾ cast predominantly base metal	$85
D2782	Crown – ¾ cast noble metal	$85
D2790	Crown – full cast high noble metal	$85
D2791	Crown – full cast predominantly base metal	$85
D2792	Crown – full cast noble metal	$85
D2794	Crown – titanium	$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	$0
D2931	Prefabricated stainless steel crown – permanent tooth	$0
D2940	Protective restoration	$0
D2970	Temporary crown (fractured tooth)	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
	Endodontics	
	• *All procedures exclude final restoration.*	
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$30
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$30
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$30
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$30
D3346	Retreatment of previous root canal therapy – anterior	$30
D3347	Retreatment of previous root canal therapy – bicuspid	$30
D3348	Retreatment of previous root canal therapy – molar	$30
D3351	Apexification/recalcification – initial visit	$0
D3410	Apicoetomy – anterior	$30
D3421	Apicoetomy – bicuspid (first root)	$30
D3425	Apicoetomy – molar (first root)	$30
D3426	Apicoetomy (each additional root)	$30
D3430	Retrograde filling – per root	$0
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	$20
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	$23
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	$200
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	$150
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	$200
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	$150
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$0
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$0
	Removable Prosthodontics	
	• *Replacement limit 1 every 3 years.*	
	• *Denture relines: Twice in one year*	
	• *Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$100
D5120	Complete denture – mandibular	$100
D5130	Immediate denture – maxillary	$100
D5140	Immediate denture – mandibular	$100
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$125

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$125
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$125
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$125
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5510	Repair broken complete denture base	$0
D5520	Replace missing or broken teeth – complete denture (each tooth)	$0
D5610	Repair resin denture base	$0
D5620	Repair cast framework	$0
D5630	Repair or replace broken clasp	$0
D5640	Replace broken teeth – per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$30
D5731	Reline complete mandibular denture (chairside)	$30
D5740	Reline maxillary partial denture (chairside)	$30
D5741	Reline mandibular partial denture (chairside)	$30
D5750	Reline complete maxillary denture (laboratory)	$30
D5751	Reline complete mandibular denture (laboratory)	$30
D5760	Reline maxillary partial denture (laboratory)	$30
D5761	Reline mandibular partial denture (laboratory)	$30
D5821	Interim partial denture (mandibular)	$30
	Crowns/Fixed Bridges - Per Unit	
	• *An additional charge will be applied for any procedure using noble or high noble metal.*	
	• *$75 fee per crown/bridge unit above co-pay for porcelain on molars.*	
D6210	Pontic – cast high noble metal	$85
D6211	Pontic – cast predominantly base metal	$85
D6212	Pontic – cast noble metal	$85
D6214	Pontic – titanium	$85
D6240	Pontic – porcelain fused to high noble metal	$85
D6241	Pontic – porcelain fused to predominantly base metal	$85
D6242	Pontic – porcelain fused to noble metal	$85
D6250	Pontic – resin with high noble metal	$85
D6251	Pontic – resin with predominantly base metal	$85
D6252	Pontic – resin with noble metal	$85
D6720	Crown – resin with high noble metal	$85

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D6721	Crown – resin with predominantly base metal	$85
D6722	Crown – resin with noble metal	$85
D6750	Crown – porcelain fused to high noble metal	$85
D6751	Crown – porcelain fused to predominantly base metal	$85
D6752	Crown – porcelain fused to noble metal	$85
D6780	Crown – ¾ cast high noble metal	$85
D6781	Crown – ¾ cast predominantly base metal	$85
D6782	Crown – ¾ cast noble metal	$85
D6790	Crown – full cast high noble metal	$85
D6791	Crown – full cast predominantly base metal	$85
D6792	Crown – full cast noble metal	$85
D6794	Crown – titanium	$85
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$0
	Oral Surgery	
	• *Includes routine post operative visits/treatment.*	
	• *Surgical removal of impacted teeth - (not covered unless pathology [disease] exists).*	
	• *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	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$0
D7220	Removal of impacted tooth – soft tissue	$25
D7230	Removal of impacted tooth – partially bony	$25
D7240	Removal of impacted tooth – completely bony	$25
D7250	Surgical removal of residual tooth roots (cutting procedure)	$0
D7285	Biopsy of oral tissue – hard (bone, tooth)	$0
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
D7471	Removal of lateral exostosis (maxilla or mandible)	$0
D7472	Removal of torus palatinus	$0
D7473	Removal of torus mandibularis	$0
D7510	Incision and drainage of abscess – intraoral soft tissue	$0
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Your and Your Dependent's Co-Payment
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	$0
D7963	Frenuloplasty	$0
	Orthodontics	
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	$1,350
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	$1,350
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	$1,350
D8660	Pre-orthodontic treatment visit	$25
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8693	Rebonding or recementing of fixed retainers	$0
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
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	$20
D9440	Office visit – after regularly scheduled hours	$0
•	Broken appointment (less than 24 hour notice)	

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 dentist whose practice is limited to providing Specialty Care, not contracted with SafeGuard without prior approval by SafeGuard, (except for out of area emergency services).
2. 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.
3. Any procedures not specifically listed as a covered benefit in the *Schedule of Benefits.*
4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
5. Orthognathic surgery.
6. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
7. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse,or neglect.
8. Treatment of malignancies, cysts, or neoplasms.
9. 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*.
10. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
11. Precision attachments.
12. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
13. 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.
14. 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.
15. Services considered unnecessary or experimental in nature.
16. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
17. 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. Full-mouth X-rays: Once initially and thereafter when diagnostically necessary.
4. Dentures (full or partial): Replacement only after three (3) 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 Selected General dentist.
5. Denture relines: Twice in one year
6. Sealants are a covered benefit only when they are listed as a covered service on your plan's *Schedule of Benefits*. If covered, the plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
7. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
8. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.

9. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
10. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.
11. The co-payments listed for endodontic procedures do not include the cost of final restoration.
12. Periodontal maintenance procedures are a covered benefit only when listed as a covered service on your plan's *Schedule of Benefits*. If covered, periodontal maintenance procedures must follow active periodontal therapy, and are limited to 2 in a 12 month period.
13. General anesthesia is a covered benefit only when it is listed as a covered service on your plan's *Schedule of Benefits*, and when it is administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted dentist whose practice is limited to providing Specialty Care 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 or phase I orthodontics;
    e. Changes in treatment necessitated by an accident;
    f. 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. Lingually placed direct bonded appliances and arch wires (“invisible braces”); and
        v. Functional appliances that are used in conjunction with fixed appliances.
    g. Diagnostic records:
        i. Cephalometric x-rays and other x-rays;
        ii. Diagnostic tracings of cephalometric x-rays;
        iii. Photographs; and
        iv. Study models.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Should a member or client terminate from the Plan for any reason and at that time be receiving orthodontic treatment, the Member and not SafeGuard shall be responsible for payment of the balance due for any orthodontic treatment performed after termination. The member’s payment shall be increased by an additional $1,750 above the member’s co-payment and excluding any charges for diagnostic records, shall be prorated over the number of months to completion of active treatment, and be payable on such terms and conditions as are arranged between the Member and the orthodontist.
6. The retention phase of treatment, if required, shall include the construction, placement and adjustment of retainers, the maximum cost of which shall not exceed $250.00.
7. If a member does not require treatment or chooses not to start treatment after the participating SafeGuard orthodontist has completed a diagnosis and consultation, the Member will be charged a consultation fee of $25.00 in addition to the fees for such diagnostic records.