DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

General

1. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures or when deemed necessary by the treating dentist

Diagnostic

1. Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.

2. All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

1. Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the Co-Payment listed in the SCHEDULE OF BENEFITS. Additional Prophylaxis are available, if Dentally Necessary.

2. Sealants and/or preventive resin restorations: Plan benefit applies to primary and permanent molar teeth, limited to age 19, one (1) per tooth, per thirty-six (36) months, unless Dentally Necessary.

3. Space maintainers are covered to age 14 once per area, per lifetime. Replacement of lost space maintainers is not a Covered Service.

Restorative Treatment

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.

2. Cases involving seven (7) or more Crowns 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 or Bridge unit.

3. There is a $75 Co-Payment per molar, for the use of porcelain.

4. Prefabricated stainless steel Crowns or prefabricated resin Crowns are limited to no more than one (1) replacement for the same tooth surface within five (5) years.

5. Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.

6. Provisional and Interim Crowns/restorations are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.

7. Replacement of any Cast Restorations with the same or a different type of Cast Restoration are limited to no more than once every five (5) years.

8. Core buildups are limited to no more than once per tooth in a period of five (5) years.

9. Post and cores are limited to no more than once per tooth in a period of five (5) years.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

10. Labial veneers are limited to no more than once per tooth in a period of five (5) years.

Prosthodontics

1. Relinings and rebasings are limited to one (1) every twelve (12) months.

2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist.

3. Replacement of an immediate full Denture with a permanent full Denture if the immediate full Denture cannot be made permanent and such replacement is done within twelve (12) months of the installation of the immediate full Denture.

4. Adjustments of Dentures if at least six (6) months have passed since the installation of the existing removable Denture.

5. Delivery of removable and fixed Prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

6. Tissue conditioning eligible one (1) per appliance each twenty-four (24) months.

7. Provisional and Interim prostheses are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.

Endodontics

1. The Co-Payments listed for Endodontic procedures do not include the cost of the final restoration.

2. Materials used for canal irrigation are included in the Endodontic procedure fees.

Oral Surgery

1. The removal of asymptomatic third molars is not a Covered Service. Pathology (disease) must exist for it to be covered by the program.

2. Includes routine post operative visits/treatments.

Periodontics

1. Irrigation (such as Chlorhexidine) is included with the other services rendered that day.

2. Local chemotherapeutic agents are limited to no more than six (6) teeth per arch. Treatment plans involving more than six (6) teeth per arch require prior Plan approval.

3. Periodontal maintenance is eligible following active periodontal therapy, which includes scaling and root planing, surgery, etc.

4. Periodontal scaling and root planing is limited to not more than once per Quadrant in any twenty-four (24) month period.

5. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.

6. Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.

Orthodontic Exclusions and 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 the 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 charge of 75% of your Safeguard selected general dentist's or Safeguard contracted orthodontist's usual and customary fees.

3. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

4. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

5. 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.

        v. Invisalign services are excluded.

DENTAL BENEFITS: EXCLUSIONS

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS, are not covered.

2. Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and schedule of benefits (except for out-of-area emergency services).

3. Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (the tooth has been opened into the pulp (nerve chamber)), or full or partial Dentures for which an impression has been taken.

4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.

5. Orthognathic surgery.

6. Inpatient/outpatient hospital charges of any kind, including prescriptions or medications. General anesthesia or IV sedation is not covered for any reason if rendered in an out patient facility or hospital. Dental charges will be covered, if the procedure performed is covered by the Plan.

7. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.

8. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.

9. Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.

10. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.

11. 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.

12. Dental services required while serving in the Armed Forces of any country or international authority.

13. Dental services considered Experimental in nature.
    Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

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

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) 880-1800.

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) 880-1800.

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**。