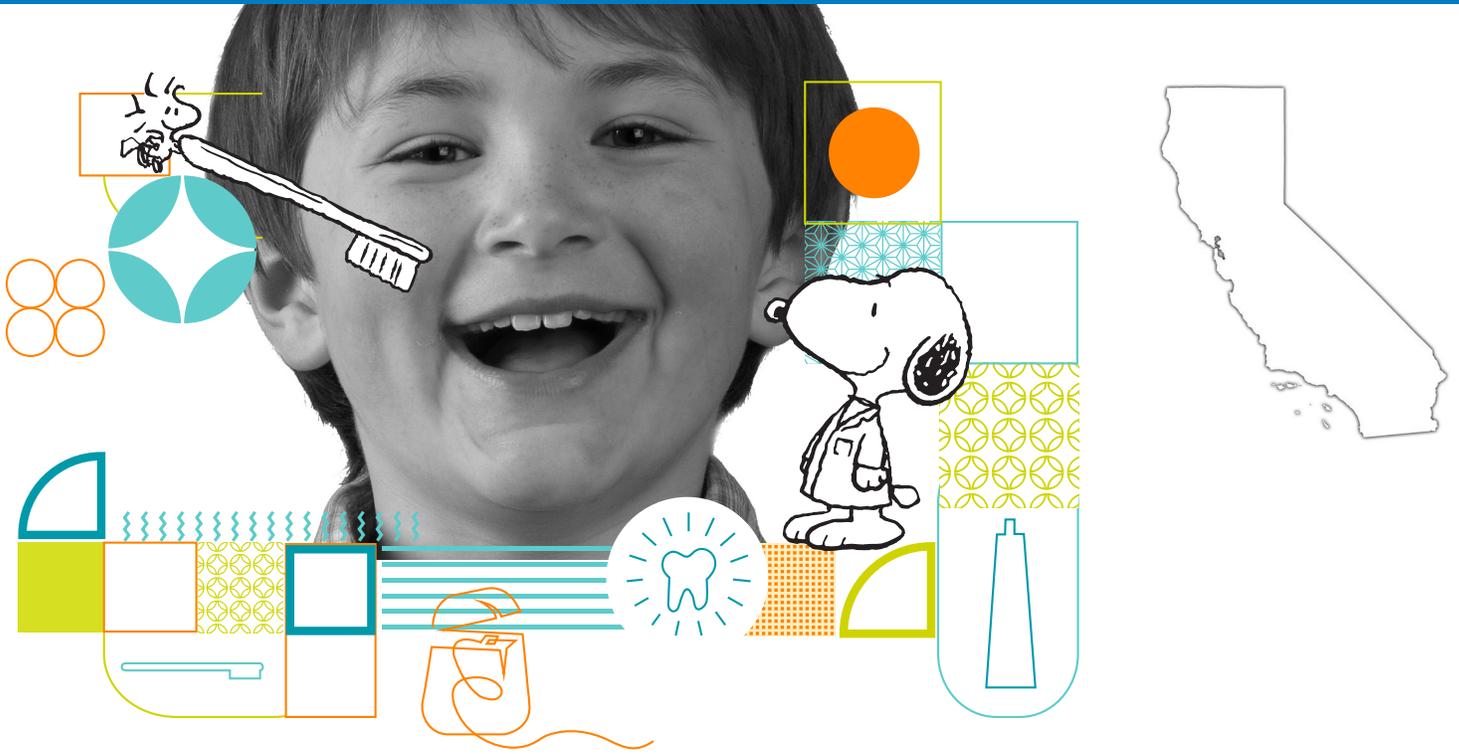


# MetLife



Competitively Priced  
Dental Benefits  
for Healthy Living

Routine dental exams do more than protect your teeth. They can help protect your health by catching serious problems, such as diabetes and heart disease. Dental benefits make it more affordable to see a dentist regularly. With MetLife Dental HMO/Managed Care plans, you'll get:

- **Lower out-of-pocket costs** on dental procedures.<sup>1</sup>
- **Broad network** of participating dentists.
- **Hassle-free benefits.**
- **A commitment to your oral health.**

Plus, you'll get service you can count on. Now that's refreshing.

MetLife Family Dental HMO Plan is a Qualified Health Plan in Covered California.

## What you'll find inside

In this booklet, you'll find all the information you need to make an educated choice about purchasing Dental HMO/Managed Care benefits:

- An overview of the benefits of purchasing MetLife Dental HMO/Managed Care plans
- How to get the most savings out of your dental benefits
- Highlights of the MetLife Family Dental HMO Plan
- Important answers to some common questions

We designed our Dental HMO/Managed Care benefits to help you get the dental care for a wide range of covered services and help lower your costs.

The goal is to deliver competitively priced protection for a healthier smile and a healthier you. You also get educational support to help you stay on top of your care and great service.

## Lower out-of-pocket costs on dental procedures

This plan provides savings on services that help you keep your mouth healthy. For all covered services, you are responsible for just the copayments, which are considerably lower than your cost would be without dental benefits.<sup>2</sup>

Here are some of the services included in this plan:

- Preventive Services (exams, sealants, x-rays)
- White fillings on back (posterior) teeth
- Porcelain and gold crowns
- Orthodontia
- Root canals and retreatment
- Osseous surgery, periodontal maintenance
- General anesthesia, IV sedation & nitrous oxide
- Up to 2 cleanings per year
- Cancer screenings (brush biopsies)
- Extractions

For a full listing of all covered services and copayments, covered percentage for each, please refer to the dental plan benefits summary.

## Broad network of participating dentists

There are hundreds of participating general dentists to choose from statewide — so you are sure to find one who meets your needs. Each enrolled family member may select a different participating general dentist.

So you can feel confident about choosing a participating dentist, our participating dentists are carefully selected to support quality and savings. In fact, requirements include ongoing reviews of treatment patterns to ensure they fall within acceptable norms.

## Hassle-free benefits

With a Dental HMO/Managed Care benefit plan, you don't have to worry about deductibles or filling out paperwork for claims. After your plan's effective date, just call your participating dentist to schedule your appointment. When you receive dental services from your participating dentist, you are only responsible for the copayment listed in the dental plan benefits summary for any covered services received.

Plus, if you need specialty care, no problem. Your participating dentist will provide you with the name of a participating specialist. Just call that specialist to schedule your appointment.<sup>3</sup> Copayment amounts for specialty services are listed on your dental plan benefits summary. These copayments apply whether the services are provided by your participating general dentist or by a participating specialist.

## A commitment to your oral health

You and your dentist get a wealth of information and valuable tools to help make informed decisions about your oral health. You'll find a range of helpful topics on our online dental education website, [www.metlife.com/dental](http://www.metlife.com/dental). Read up on topics like family dental health, the link between dental and overall health, and kid's dental health. Plus, you can take risk assessments to better understand your personal risk for dental disease.

## Service where and when you want it

Managing your dental benefits is easy with MyBenefits ([www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)), your secure self-service website. It's available 24/7.<sup>4</sup> You can use the site to:

- View your dental plan benefits summary and check the co-payment amounts
- Locate a participating dentist
- Change participating dentists
- Print ID cards
- Access oral health education

Plus, you can call us toll-free at 1-855-638-3940.

## How to get the most savings out of your dental benefits

It's easy to get the most out of your Dental HMO/Managed Care benefits.

**Keep a healthy dental regimen** by getting routine preventive services like exams and cleanings. The copayments for preventive services are usually less than the copayments for fillings, root canals, extractions, etc. Plus, preventive services can help you avoid the need for these higher-cost treatments.

**Visit your participating dentist.** If you need specialty care, be sure to ask your participating dentist for the name of a participating specialist. This will help reduce your out-of-pocket costs.

### Highlights of the MetLife Family Dental HMO Plan

MetLife Family Dental HMO Plan	
Out-of-Pocket Annual Maximums	
One Participant Under the Age of 19	\$350
Two or More Participants Under the Age of 19	\$700
Member Copayments for Some Frequently Used Services	
Preventive Services	
Examinations	\$0
Full-mouth X-rays	\$0
Intraoral X-rays	\$0
Extraoral X-rays	\$0
Bitewing X-rays	\$0
Cleanings	\$0
Flouride	\$0
Sealents	\$0
Space Maintainers	\$0
Basic Restorative Services	
Problem-focused Examinations	\$0
Amalgam Fillings – One Surface	\$25
Resin Composite Fillings – One Surface	\$25
Extractions	\$60
Major Restorative Services	
Inlay – Metallic – One Surface	\$100
Inlay – Porcelain/Ceramic – One Surface	\$100
Onlay – Metallic – Two Surfaces	\$100
Onlay – Porcelain/Ceramic – Two Surfaces	\$100

Crown – Resin-based Composite	\$300
Crown – Resin with Noble Metal	\$300
Crown – Porcelain/Ceramic Substrate	\$300
Root Canal	\$300
Scaling and Root Planing – One to Three Teeth Per Quadrant	\$15
Periodontal Maintenance	\$15
Brush Biopsy	\$0
Orthodontia	
Orthodontia (medically necessary)	\$350

For a full listing of all covered services and copayments, covered percentage for each, please refer to the plan's benefits summary.

## Important answers to some common questions

### General Plan Questions

#### How does this plan work?

This Dental HMO/Managed Care plan is designed to support you in maintaining and improving your oral health, providing coverage on hundreds of procedures. There are no deductibles or filling out paperwork for claims, making it easier for you to receive the preventive care you need to help avoid more costly procedures.

With this plan, you are responsible for the copayment associated with each covered procedure when you visit your selected participating dentist. Typically, the copayments for preventive services like cleanings and oral examinations are lower than the copayments for basic restorative services like fillings, major restorative services like root canals, and orthodontia (services that help fix problems with the teeth and jaw).

Please refer to the dental plan benefits summary for a full list of covered services, copayment amounts, information on any limitations and additional charges for certain procedures that may apply, and what is not covered by the plan.

#### Who can enroll?

You can enroll your entire family in the MetLife Family Dental HMO Plan. This family plan includes coverage for you and your lawful spouse or domestic partner, and your unmarried children through age 23.

#### Will I receive an ID card?

Yes. However, you do not need an ID card to access your benefits. After your enrollment information is processed, we will mail you a letter with important information and an ID card. The ID card will include your assigned unique identifying number. Your dentist must use your personal identification number when he or she verifies eligibility and checks coverage.

## Network and Provider Questions

### **Do I need to select a participating (in-network) dentist when I enroll?**

No. For California plans, a person's participating dentist will be automatically assigned to him or her. After enrollment, participants may select different participating dentists. You can change dentists online at MyBenefits ([www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)) or by calling Customer Service at 1-855-638-3940.

### **Can I change dentists?**

Yes. Participants may change dentists as often as once per month. You can change dentists online at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) or by calling Customer Service at 1-855-638-3940.

Your transfer will be effective the first of the following month. Any requests made after the 25<sup>th</sup> of the month will occur effective the first of the following month (e.g., a facility request change made on March 28<sup>th</sup> will go into effect on May 1<sup>st</sup>).

Please note: you should ensure any dental work-in-progress is completed prior to transferring to a new dentist.

### **What if I need to see a specialist?**

This is a "direct referral" plan, which means your selected participating dentist will refer you to a participating specialist in your area. There is no need to wait for approval.<sup>3</sup> Copayment amounts for services are listed on your dental plan benefits summary. These copayments apply whether the services are provided by your selected participating general dentist or by a participating specialist.

### **Can my dentist apply for participation in the network?**

Yes. If your current dentist does not participate in the network, we will be happy to accept your nomination. Just call Customer Service, or to submit your nomination online, visit the MyBenefits website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) and click the "Find a Dentist" link. Once submitted, we will contact that dentist and provide them with an application to join our dental network.<sup>5</sup>

## Benefit Questions

### **What is an out-of-pocket annual maximum?**

The out-of-pocket annual maximum is the most you pay during a Plan Year in cost-sharing for participants under the age of 19 before we begin to pay 100% of the maximum allowed charge for covered services. This limit does not include your premium, balance billing charges or the cost of health care services we do not cover.

### **What if I need emergency care?**

All participating dental offices provide emergency access 24 hours a day, 7 days a week. If you cannot reach your selected participating dentist, you may receive emergency care from any licensed dental care professional.

**Does this plan cover second opinions?**

Yes. Just contact Customer Service to let us know that you would like another clinical opinion and we will provide the name of a dentist for you to see.

<sup>1</sup> Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

<sup>2</sup> Certain limitations apply to some services; please review your dental plan benefits summary for full details.

<sup>3</sup> In California, orthodontic and pedodontic specialty services require pre-approval. Your participating dentist will contact Safeguard for pre-approval. Once approved, your dentist will contact you with the name of a participating specialist.

<sup>4</sup> With the exception of scheduled or unscheduled systems maintenance or interruptions, the MyBenefits website is typically available 24 hours a day, 7 days a week.

<sup>5</sup> Due to contractual requirements, MetLife is prevented from soliciting certain providers.

Dental Managed Care plan benefits are provided by Metropolitan Life Insurance Company, a New York corporation, in NY. Dental HMO plan benefits are provided by: SafeGuard Health Plans, Inc. a California corporation, in CA; SafeGuard Health Plans, Inc. a Florida corporation, in FL; SafeGuard Health Plans, Inc., a Texas corporation, in TX; and MetLife Health Plans, Inc., a Delaware corporation, and Metropolitan Life Insurance Company, a New York corporation, in NJ. The Dental HMO/Managed Care companies are part of the MetLife family of companies.

“DHMO” is used to refer to product designs that may differ by state of residence of the enrollee, including but not limited to: “Specialized Health Care Service Plans” in California; “Prepaid Limited Health Service Organizations” as described in Chapter 636 of the Florida statutes in Florida; “Single Service Health Maintenance Organizations” in Texas; and “Dental Plan Organizations” as described in the Dental Plan Organization Act in New Jersey.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

# MetLife

**Metropolitan Life Insurance Company**

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**Direct Referral Dental**                      **Benefits provided by SafeGuard Health Plans, Inc., a MetLife Company**

**CALIFORNIA FAMILY BASIC DENTAL PLAN (HIGH DHMO)**

This SCHEDULE OF BENEFITS lists the Covered Services available to You and Your Dependent under the dental plan, as well as your costs for each Covered Service. Costs may include Co-Payments for a Covered Service.

\*Care under this plan is provided through a network of Selected General Dentists. The Selected General Dentist is responsible for: determining when the services of a Specialty Care Dentist are needed, facilitating any necessary referral and advising of the name, address and telephone number of the Specialty Care Dentist in the Covered Person’s Service Area.

Missed Appointments: If a Covered Person needs to cancel or reschedule an appointment, please notify the Selected General Dental Office as far in advance as possible. This will allow the Selected General Dental Office to accommodate another person in need of attention. Failure to do this in a timely fashion, may result in being charged a missed appointment fee.

**The Out-of-Pocket Annual Maximum Only Applies to Covered Persons Under Age 19**

- 
- Individual Out-of-Pocket Annual Maximum (1 Covered Person under age 19)**
    - In-Network..... \$350
    - Out-of-Network..... None
  - Family Out-of-Pocket Annual Maximum (2 or more Covered Persons under age 19)**
    - In-Network..... \$700
    - Out-of-Network..... None

The Out-of-Pocket Annual maximum includes the Co-Payments for Covered Services provided by the Selected General Dentist or a Specialty Care Dentist. The Out-of-Pocket Annual maximum does not include Co-Payments for: (1) services that are not Covered Services or (2) services delivered by a non-contracted provider.

Each individual is only responsible for paying the Individual Out-of-Pocket Annual Maximum for the pediatric dental Essential Health Benefits for a Covered Person under age 19. Once the Individual Out-of-Pocket Annual Maximum is satisfied, no further payment is required for Covered Services, delivered by a contracted provider, for the remainder of the Year for that Covered Person. Cost sharing payments made by each individual in a family contribute to the Out-of-Pocket Maximum. For these purposes, family is composed of 2 or more Covered Persons under the age of 19. Once the Family Out-of-Pocket Annual Maximum is satisfied by at least 2 Individual Out-of-Pocket Annual Maximums being satisfied, no further payment is required for Covered Services, delivered by a contracted provider, for Covered Persons for the remainder of the Year.

<b>Service</b>	<b>Co-Payment</b>
<ul style="list-style-type: none"> <li>• Office visit - per visit (including all fees for sterilization and/or infection control)</li> </ul>	\$0

## SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment
<b>Diagnostic Treatment</b>		
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
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0
D0171	Re-evaluation – post-operative office visit	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	\$0
D0190	Screening of a patient	\$0
D0191	Assessment of a patient	\$0
<b>Radiographs / Diagnostic Imaging (X-rays)</b>		
	<ul style="list-style-type: none"> <li>Panoramic or full mouth x-rays (including bitewings) are limited to once every two (2) years, unless Dentally Necessary for a specific dental problem.</li> </ul>	
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	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$0
D0251	Extra-oral posterior dental 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
D0277	Vertical bitewings – 7 to 8 radiographic images	\$0
D0322	Tomographic survey	\$0
D0330	Panoramic radiographic image	\$0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	\$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$0
<b>Tests and Examinations</b>		
D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
<b>Preventive Services</b>		

## SCHEDULE OF BENEFITS (continued)

	Service	Co-Payment
	<ul style="list-style-type: none"> <li>Sealants and/or preventive resin restorations are only available for a Covered Person under age 19*: Plan benefit applies to primary and permanent molar teeth.</li> <li>Prophylaxis cleanings are limited to two (2) in a twelve month (12) period.</li> <li>Space maintainers are only available for a Covered Person under age 19*.</li> <li>Fluoride treatments are only available for a Covered Person under age 19*, and 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.</li> </ul>	
	* This service is part of the plan for Covered Persons under age 19 and is therefore not available to Covered Persons age 19 and older.	
D1110	Prophylaxis – adult	\$0
	<ul style="list-style-type: none"> <li>Additional-adult prophylaxis (maximum of 2 additional per year)</li> </ul>	\$0
D1120	Prophylaxis – child	\$0
	<ul style="list-style-type: none"> <li>Additional-child prophylaxis (maximum of 2 additional per year)</li> </ul>	\$0
D1206	Topical application of fluoride varnish	\$0
D1208	Topical application of fluoride – excluding varnish	\$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
	<ul style="list-style-type: none"> <li>Includes periodontal hygiene instruction</li> </ul>	
D1351	Sealant – per tooth	\$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	\$0
D1353	Sealant repair - per tooth	\$0
D1354	Interim caries arresting medicament application	\$0
D1510	Space maintainer – fixed – unilateral	\$0
D1515	Space maintainer – fixed – bilateral	\$0
D1520	Space maintainer – removable – unilateral	\$0
D1525	Space maintainer – removable – bilateral	\$0
D1550	Re-cement or re-bond space maintainer	\$0
D1555	Removal of fixed space maintainer	\$0
	<b>Restorative Treatment</b>	
D2140	Amalgam – one surface, primary or permanent	\$25
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	\$25
D2332	Resin-based composite – three surfaces, anterior	\$25
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$25
D2390	Resin-based composite crown, anterior	\$20
D2391	Resin-based composite – one surface, posterior	\$15
D2392	Resin-based composite – two surfaces, posterior	\$15

## SCHEDULE OF BENEFITS (continued)

	Service	Co-Payment
D2393	Resin-based composite – three surfaces, posterior	\$15
D2394	Resin-based composite – four or more surfaces, posterior	\$15
<b>Crowns</b>		
	<ul style="list-style-type: none"> <li>• 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 molar, for the use of porcelain.</li> <li>• 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 or Bridge unit.</li> </ul>	
D2510	Inlay – metallic – one surface	\$100
D2520	Inlay – metallic – two surfaces	\$100
D2530	Inlay – metallic – three or more surfaces	\$100
D2542	Onlay – metallic – two surfaces	\$100
D2543	Onlay – metallic – three surfaces	\$100
D2544	Onlay – metallic – four or more surfaces	\$100
D2610	Inlay – porcelain/ceramic – one surface	\$100
D2620	Inlay – porcelain/ceramic – two surfaces	\$100
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$100
D2642	Onlay – porcelain/ceramic – two surfaces	\$100
D2643	Onlay – porcelain/ceramic – three surfaces	\$100
D2644	Onlay – porcelain/ceramic – four or more surfaces	\$100
D2650	Inlay – resin-based composite – one surface	\$100
D2651	Inlay – resin-based composite – two surfaces	\$100
D2652	Inlay – resin-based composite – three or more surfaces	\$100
D2662	Onlay – resin-based composite – two surfaces	\$100
D2663	Onlay – resin-based composite – three surfaces	\$100
D2664	Onlay – resin-based composite – four or more surfaces	\$100
D2710	Crown – resin-based composite (indirect)	\$300
D2712	Crown – ¾ resin-based composite (indirect)	\$300
D2720	Crown – resin with high noble metal	\$300
D2721	Crown – resin with predominantly base metal	\$300
D2722	Crown – resin with noble metal	\$300
D2740	Crown – porcelain/ceramic substrate	\$300
D2750	Crown – porcelain fused to high noble metal	\$300
D2751	Crown – porcelain fused to predominantly base metal	\$300
D2752	Crown – porcelain fused to noble metal	\$300
D2780	Crown – ¾ cast high noble metal	\$300
D2781	Crown – ¾ cast predominantly base metal	\$300
D2782	Crown – ¾ cast noble metal	\$300
D2783	Crown – ¾ porcelain/ceramic	\$300
D2790	Crown – full cast high noble metal	\$300
D2791	Crown – full cast predominantly base metal	\$300
D2792	Crown – full cast noble metal	\$300
D2794	Crown – titanium	\$300

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	\$30
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$0
D2920	Re-cement or re-bond crown	\$0
D2930	Prefabricated stainless steel crown – primary tooth	\$0
D2931	Prefabricated stainless steel crown – permanent tooth	\$0
D2932	Prefabricated resin crown	\$0
D2933	Prefabricated stainless steel crown with resin window	\$0
D2940	Protective restoration	\$0
D2941	Interim therapeutic restoration – primary dentition	\$0
D2950	Core buildup, including any pins when required	\$15
D2951	Pin retention – per tooth, in addition to restoration	\$10
D2952	Post and core in addition to crown, indirectly fabricated	\$40
D2953	Each additional indirectly fabricated post – same tooth	\$40
D2954	Prefabricated post and core in addition to crown	\$30
D2957	Each additional prefabricated post – same tooth	\$25
D2971	Additional procedures to construct new crown under existing partial denture framework	\$50
D2980	Crown repair necessitated by restorative material failure	\$0
D2981	Inlay repair necessitated by restorative material failure	\$0
D2982	Onlay repair necessitated by restorative material failure	\$0
D2983	Veneer repair necessitated by restorative material failure	\$0
D2990	Resin infiltration of incipient smooth surface lesions	\$0
<b>Endodontics</b>		
	• 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
D3221	Pulpal debridement, primary and permanent teeth	\$15
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	\$5
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$10
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$40
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	\$65
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$300
D3331	Treatment of root canal obstruction; non-surgical access	\$45
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$50
D3333	Internal root repair of perforation defects	\$35
D3346	Retreatment of previous root canal therapy – anterior	\$45
D3347	Retreatment of previous root canal therapy – bicuspid	\$70
D3348	Retreatment of previous root canal therapy – molar	\$90

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	\$65
D3352	Apexification/recalcification – interim medication replacement	\$30
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3355	Pulpal regeneration - initial visit	\$30
D3356	Pulpal regeneration - interim medication replacement	\$15
D3357	Pulpal regeneration - completion of treatment	\$30
D3410	Apicoectomy – anterior	\$95
D3421	Apicoectomy – bicuspid (first root)	\$95
D3425	Apicoectomy – molar (first root)	\$95
D3426	Apicoectomy (each additional root)	\$60
D3427	Periradicular surgery without apicoectomy	\$70
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	\$55
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	\$25
D3430	Retrograde filling – per root	\$10
D3450	Root amputation – per root	\$95
D3920	Hemisection (including any root removal), not including root canal therapy	\$90
	<b>Periodontics</b>	
	<ul style="list-style-type: none"> <li>Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply.</li> </ul>	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	\$65
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	\$70
D4245	Apically positioned flap	\$55
D4249	Clinical crown lengthening – hard tissue	\$120
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$260
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$170
D4263	Bone replacement graft – first site in quadrant	\$55
D4264	Bone replacement graft – each additional site in quadrant	\$25
D4270	Pedicle soft tissue graft procedure	\$135
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$65
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	\$195
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$90
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$35

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$15
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$10
D4910	Periodontal maintenance	\$15
	• Additional periodontal maintenance procedures (limit 2 additional per year)	\$45
	• Periodontal hygiene instruction	\$0
	<b>Removable Prosthodontics</b>	
	• 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 or Specialty Care Dentist.	
D5110	Complete denture – maxillary	\$325
D5120	Complete denture – mandibular	\$325
D5130	Immediate denture – maxillary	\$350
D5140	Immediate denture – mandibular	\$350
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$400
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$400
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$400
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$400
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$425
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	\$425
D5410	Adjust complete denture – maxillary	\$10
D5411	Adjust complete denture – mandibular	\$10
D5421	Adjust partial denture – maxillary	\$10
D5422	Adjust partial denture – mandibular	\$10
D5510	Repair broken complete denture base	\$35
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$35
D5610	Repair resin denture base	\$35
D5620	Repair cast framework	\$35
D5630	Repair or replace broken clasp - per tooth	\$35
D5640	Replace broken teeth – per tooth	\$35
D5650	Add tooth to existing partial denture	\$35
D5660	Add clasp to existing partial denture - per tooth	\$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$165

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$165
D5710	Rebase complete maxillary denture	\$75
D5711	Rebase complete mandibular denture	\$75
D5720	Rebase maxillary partial denture	\$75
D5721	Rebase mandibular partial denture	\$75
D5730	Reline complete maxillary denture (chairside)	\$65
D5731	Reline complete mandibular denture (chairside)	\$65
D5740	Reline maxillary partial denture (chairside)	\$65
D5741	Reline mandibular partial denture (chairside)	\$65
D5750	Reline complete maxillary denture (laboratory)	\$85
D5751	Reline complete mandibular denture (laboratory)	\$85
D5760	Reline maxillary partial denture (laboratory)	\$85
D5761	Reline mandibular partial denture (laboratory)	\$85
D5820	Interim partial denture (maxillary)	\$160
D5821	Interim partial denture (mandibular)	\$170
D5850	Tissue conditioning, maxillary	\$20
D5851	Tissue conditioning, mandibular	\$20
<b>Crowns/Fixed Bridges - Per Unit</b>		
	<ul style="list-style-type: none"> <li>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 molar, for the use of porcelain.</li> <li>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 or Bridge unit.</li> </ul>	
D6210	Pontic – cast high noble metal	\$100
D6211	Pontic – cast predominantly base metal	\$100
D6212	Pontic – cast noble metal	\$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
D6245	Pontic – porcelain/ceramic	\$100
D6250	Pontic – resin with high noble metal	\$100
D6251	Pontic – resin with predominantly base metal	\$100
D6252	Pontic – resin with noble metal	\$100
D6600	Retainer inlay – porcelain/ceramic, two surfaces	\$100
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	\$100
D6602	Retainer inlay – cast high noble metal, two surfaces	\$100
D6603	Retainer inlay – cast high noble metal, three or more surfaces	\$100
D6604	Retainer inlay – cast predominantly base metal, two surfaces	\$100
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	\$100
D6606	Retainer inlay – cast noble metal, two surfaces	\$100
D6607	Retainer inlay – cast noble metal, three or more surfaces	\$100
D6608	Retainer onlay – porcelain/ceramic, two surfaces	\$100
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	\$100

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
D6610	Retainer onlay – cast high noble metal, two surfaces	\$100
D6611	Retainer onlay – cast high noble metal, three or more surfaces	\$100
D6612	Retainer onlay – cast predominantly base metal, two surfaces	\$100
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	\$100
D6614	Retainer onlay – cast noble metal, two surfaces	\$100
D6615	Retainer onlay – cast noble metal, three or more surfaces	\$100
D6720	Retainer crown – resin with high noble metal	\$300
D6721	Retainer crown – resin with predominantly base metal	\$300
D6722	Retainer crown – resin with noble metal	\$300
D6740	Retainer crown – porcelain/ceramic	\$300
D6750	Retainer crown – porcelain fused to high noble metal	\$300
D6751	Retainer crown – porcelain fused to predominantly base metal	\$300
D6752	Retainer crown – porcelain fused to noble metal	\$300
D6780	Retainer crown – ¾ cast high noble metal	\$300
D6781	Retainer crown – ¾ cast predominantly base metal	\$300
D6782	Retainer crown – ¾ cast noble metal	\$300
D6783	Retainer crown – ¾ porcelain/ceramic	\$300
D6790	Retainer crown – full cast high noble metal	\$300
D6791	Retainer crown – full cast predominantly base metal	\$300
D6792	Retainer crown – full cast noble metal	\$300
D6930	Re-cement or re-bond fixed partial denture	\$0
D6940	Stress breaker	\$110
D6980	Fixed partial denture repair necessitated by restorative material failure	\$20
D6985	Pediatric partial denture, fixed	\$0
	<b>Oral Surgery</b>	
	<ul style="list-style-type: none"> <li>• Includes routine post operative visits/treatment.</li> <li>• The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists.</li> </ul>	
D7111	Extraction, coronal remnants – deciduous tooth	\$60
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	\$15
D7220	Removal of impacted tooth – soft tissue	\$20
D7230	Removal of impacted tooth – partially bony	\$35
D7240	Removal of impacted tooth – completely bony	\$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$165
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$5
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$15
D7280	Surgical access of an unerupted tooth	\$15
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$15
D7283	Placement of device to facilitate eruption of impacted tooth	\$15
D7286	Incisional biopsy of oral tissue – soft	\$0

## SCHEDULE OF BENEFITS (continued)

	<b>Service</b>	<b>Co-Payment</b>
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
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$110
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	\$315
D7471	Removal of lateral exostosis (maxilla or mandible)	\$80
D7472	Removal of torus palatinus	\$15
D7473	Removal of torus mandibularis	\$15
D7510	Incision and drainage of abscess – intraoral soft tissue	\$15
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	\$0
D7970	Excision of hyperplastic tissue – per arch	\$55
D7971	Excision of pericoronal gingiva	\$35
<b>Orthodontics</b>		
	<ul style="list-style-type: none"> <li>Benefits are available only for a Covered Person under age 19* and cover twenty-four (24) months of Medically Necessary Orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of \$25.</li> <li>Comprehensive Orthodontic benefits include all Medically Necessary phases of treatment and fixed/removable appliances.</li> </ul>	
	* This service is part of the plan for Covered Persons under age 19 and is therefore not available to Covered Persons age 19 and older.	
D8010	Limited orthodontic treatment of the primary dentition	\$350
D8020	Limited orthodontic treatment of the transitional dentition	\$350
D8030	Limited orthodontic treatment of the adolescent dentition	\$350
D8040	Limited orthodontic treatment of the adult dentition	\$350
D8050	Interceptive orthodontic treatment of the primary dentition	\$350
D8060	Interceptive orthodontic treatment of the transitional dentition	\$350
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$350
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$350
D8090	Comprehensive orthodontic treatment of the adult dentition	\$350
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$35
D8670	Periodic orthodontic treatment visit	\$35
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300
D8681	Removable orthodontic retainer adjustment	\$0
D8693	Re-cement or re-bond fixed retainers	\$0
D8694	Repair of fixed retainers, includes reattachment	\$0
	<ul style="list-style-type: none"> <li>There is a Co-Payment of \$250 for Orthodontic treatment planning and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models).</li> </ul>	

## SCHEDULE OF BENEFITS (continued)

- There is a Co-Payment of \$25 per visit for Orthodontic visits beyond twenty-four (24) months of active treatment or retention.

### Adjunctive General Services

- General anesthesia or IV sedation is a Covered Service only if it is provided in a Selected General Dental Office, administered by the Selected General Dentist or Specialty Care Dentist, and is in conjunction with covered oral and periodontal surgical procedures or when deemed medically necessary by the Selected General Dentist or Specialty Care Dentist.

D9110	Palliative (emergency) treatment of dental pain	\$0
D9120	Fixed partial denture sectioning	\$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9219	Evaluation for deep sedation or general anesthesia	\$0

	<b>Service</b>	<b>Co-Payment</b>
D9223	Deep sedation/general anesthesia – each 15 minute increment	\$60
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$15
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	\$60
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	\$0
D9440	Office visit – after regularly scheduled hours	\$15
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9932	Cleaning and inspection of removable complete denture, maxillary	\$0
D9933	Cleaning and inspection of removable complete denture, mandibular	\$0
D9934	Cleaning and inspection of removable partial denture, maxillary	\$0
D9935	Cleaning and inspection of removable partial denture, mandibular	\$0
D9940	Occlusal guard, by report	\$85
D9950	Occlusal analysis – mounted case	\$50
D9951	Occlusal adjustment – limited	\$0
D9952	Occlusal adjustment – complete	\$0
D9986	Missed appointment (less than 24-hr notice)	Not to exceed \$25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	\$0

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## DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

### General

1. Specialty Care Dentists will accept the contracted fee for all Covered Services.
2. Services which are not Dentally Necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.
3. General anesthesia or IV sedation is a Covered Service only if it is provided in a Selected General Dental Office, administered by the Selected General Dentist or Specialty Care Dentist, and is in conjunction with covered oral and periodontal surgical procedures or when deemed medically necessary by the Selected General Dentist or Specialty Care Dentist.
4. Sterilization and infection control are not billable to Us or the Covered Person and are included within the charges for other services provided on that date of service.
  - a. Local Anesthetic is included in all restorative and surgical procedure fees.
  - b. All adhesives, liners, bases and occlusal adjustments are included as a part of the restorative procedure.

### Diagnostic

1. Panoramic or full mouth x-rays: once every 24 consecutive months, unless Dentally Necessary for a specific dental problem. Bitewing x-rays: one series of 4 films in any six (6) consecutive months. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
2. All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to the Covered Person are included in the costs for the full mouth x-ray.

### Preventive

1. Fluoride treatments are only available for a Covered Person under age 19\*, and are limited to twice a year.
2. Prophylaxis cleanings are limited to two (2) in a twelve month (12) period. 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.
3. Space maintainers are only available for a Covered Person under age 19\*.
4. Sealants and/or preventive resin restorations are only available for a Covered Person under age 19\*: Plan benefit applies to primary and permanent molar teeth.

\* This service is part of the plan for Covered Persons under age 19 and is therefore not available to Covered Persons age 19 and older.

### Restorative Treatment

#### Fillings, Crowns and Fixed Bridges

1. Restorations are limited as follows:
  - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a Covered Service.
  - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.
2. Amalgam fillings include pins and pin build up in conjunction with a restoration.
3. Resin composite fillings include pins and pin build up in conjunction with a restoration.

## **DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)**

4. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
5. Crowns will include related dowel pins and pin buildup and cast retention under crowns.
6. An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
7. 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 or Bridge unit.
8. There is a \$75 Co-Payment per molar, for the use of porcelain.
9. Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.
10. Provisional Crowns/restorations are to be used for an interim of at least six (6) months duration. 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.
11. Recementations include recementation of crowns, bridges, inlays and onlays.
12. A sedative base and sedative filings are covered services.

### **Prosthodontics**

1. Dentures (full or 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 or Specialty Care Dentist.
2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
4. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant is responsible for all additional charges.
5. Replacement of an immediate full Denture with a permanent full Denture if the immediate full Denture cannot be made permanent.
6. Fixed partial dentures are limited as follows:
  - For a Covered Person 16 years of age or older a fixed partial Denture is covered when it is necessary to replace a missing permanent anterior tooth and the patient's oral health and general dental condition permits.
  - For a Covered Dependent under the age of 16, a fixed partial Denture is considered optional dental treatment and the applicant must pay the difference in cost between the fixed partial denture and a space maintainer.
  - A fixed partial Denture will be used only when a partial cannot satisfactorily restore the case. If fixed partial dentures are used when a partial could satisfactorily restore the case, it is considered optional treatment.

## **DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)**

- Fixed partial Dentures used to replace missing posterior teeth are considered optional when the abutment teeth are medically sound and would be crowned only for the purpose of supporting a pontic.
  - Fixed partial Dentures are optional when provided in connection with a partial Denture on the same arch.
  - Replacement of an existing fixed partial Denture is covered only when it cannot be made satisfactory by repair.
7. Provisional prostheses are to be used for an interim of at least six (6) months duration. 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.
8. Dentures include clasps and stress breakers, denture duplication and stayplates.

### **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.
3. Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal is not a Covered Service, in the absence of pathology, is not a Covered Service.
4. Root canal therapy includes culture canals.
5. Pulpotomy includes vital pulpotomy treatment.

### **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.
3. Oral Surgery includes the following:
  - alveolectomies;
  - excision of cysts and neoplasms;
  - treatment of palatal torus;
  - treatment of mandibular torus;
  - frenectomy;
  - incision and drainage of abscesses;
  - post-operative services, including exams, suture removal, and treatment of complications;
  - root recovery;
  - root amputation;
  - apicoectomy;
  - vitality tests;
  - fixed bridges;
  - local anesthetics;
  - oral sedatives; and
  - nitrous oxide.

### **Periodontics**

1. Irrigation (such as Chlorhexidine), is included with the other services rendered that day.
2. Periodontal maintenance is eligible following active periodontal therapy, which includes scaling and root planing, surgery, etc.

## DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

3. Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply.
4. Periodontal surgery includes periodontal abscess and acute periodontitis.

### Orthodontics

1. Benefits are only available for a Covered Person under age 19\* and must be Medically Necessary.
2. If the Covered Person requires the services of an orthodontist, a referral must first be facilitated by the Dependent's Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, the Covered Person will be responsible for all costs associated with any Orthodontic treatment.
3. We strongly recommend that you get a pretreatment estimate of proposed orthodontic services and then discuss that estimate with the Selected General Dentist before the services are delivered. Even though pretreatment estimates are not guarantees of benefits, obtaining a pretreatment estimate is an important part of making a well-informed decision about orthodontic services, including what your plan may or may not cover under the Essential Health Benefit requirements. Please contact our Customer Service Department at (800) 880-1800 to request a pretreatment estimate.
4. If the Covered Person terminates coverage from the SafeGuard Plan after the start of Orthodontic treatment, the Covered Person will be responsible for any additional charges incurred for the remaining Orthodontic treatment.
5. Orthodontic treatment must be provided by a Selected General Dentist or Specialty Care Dentist whose specialty is orthodontics or pediatric dentistry for the Co-Payments listed in this SCHEDULE OF BENEFITS to apply.
6. 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 \$25 per visit.
7. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
8. Continuing Orthodontic treatment is available if the Covered Person qualifies by enrolling within 30 days of the Effective Date for an eligible policyholder; the Covered Person had Orthodontic coverage under the policyholder's prior plan and was in active Orthodontic treatment, covered by that Plan, as of the Effective Date of this contract. Upon receipt of a completed Continuing Orthodontic Form by Us, with all supporting documentation, We will accept liability for continuing payment of the remaining balance owed, up to a maximum of \$1,500 times the percentage of the total treatment remaining as of this contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS. The Continuing Orthodontic provision is not available:
  - thirty (30) days after this contract's Effective Date;
  - for non-Medically Necessary Orthodontia;
  - to a person who enrolls after the contract's Effective Date; or
  - to a person who is not in active Orthodontic treatment as of the Effective Date of this contract.

\* This service is part of the plan for Covered Persons under age 19 and is therefore not available to Covered Persons age 19 and older.

1. Services which, in the opinion of the attending Dentist, are not necessary to the Covered Person's dental health.
2. Covered Services must be performed by the Covered Person's Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom the Covered Person was referred in accordance with the terms of the Covered Person's 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 the Covered Person's Selected General Dentist, in accordance with the terms of the Covered Person's evidence of coverage and SCHEDULE OF BENEFITS (except for out-of-area emergency services).
3. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Schedule of Benefits.
4. Replacement of lost space maintainers are not a Covered Service.
5. Cosmetic dental care, including but not limited to, non-medically necessary orthodontic treatment and pre/post services for non-medically necessary orthodontic treatment.
6. Experimental procedures.
7. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. MetLife shall provide services at the time of need and the Covered Person will cooperate to assure that MetLife is reimbursed for such benefits.
8. Services which were provided without cost to the Covered Person by State government or an agency thereof, or any municipality, county or other subdivisions.
9. Hospital charges of any kind.
10. Major surgery for fractures and dislocations.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the covered Person became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Covered Person.
16. Implant-related services, including the removal of implants.
17. Services of a pedodontist/pediatric Dentist for a Covered Person, except when the Covered Person is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric Dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric Dentist. Note: There is a \$5.00 copayment for Covered dependents under six years of age, who are unable to be treated by their panel provider and who have been referred to a pedodontist/pediatric Dentist.