

Met Life – Safeguard DHMO DENTAL PLAN*
ENROLLMENT INSTRUCTIONS

Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.

**MEMBER /
APPLICANT
INFORMATION:**

Member/Applicant: _____
Local REALTOR® Assoc. Name: _____
E-Mail Address: _____
Requested effective date of coverage: **1st** of _____

New Enrollee [] Current Benefits Store Member Changing Plans []

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association or a W2 Employee of
a member firm.

**SELECTING
YOUR PLAN:**

[] Met Life-Safeguard DHMO

**COMPLETING THE
APPLICATION:**

USE BLACK INK AND COMPLETE ALL SECTIONS

**EFFECTIVE
DATE OF
COVERAGE:**

Applications are accepted (must be received in our office) be the 15th of the current month for coverage to be effective the 1st of the following month.

To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.

Applications are batched by group to the insurers monthly. Any application received after the 15th of the current month will be part of the next month's application batch.

TO ENROLL:

Review the application for accuracy, sign, date, and return to us with your premium.
Make checks Payable to **The Benefits Store Trust Account.**

U.S. MAIL(1st Class or Priority)

ATTN: ENROLLMENT
Benefits Store, Inc.
PO Box 238, Alamo, CA 94507

**PROCESSING
REQUIREMENT:**

NOTE: Incomplete applications or applications without the correct premium included cannot be processed.

One (1) months premium is required with your application.

Met Life – Safeguard DHMO DENTAL PLAN*

ENROLLMENT INSTRUCTIONS

PREMIUM

PAYMENTS:

(4) ways to pay your monthly premium:

Electronic Funds Transfer (EFT)

Monthly Invoice/Check

On-Line Bill Payment

Credit Card Payment/Visa, MasterCard, Discover or American Express

For your convenience we have included an EFT Authorization form with the Enrollment Form.

APPLICATION PROCESSING:

Allow 7 business days after the 15th of the current month for the processing of your application and for you to appear in the Dental Plan's database. An Email Confirmation will be automatically generated to you with your group policy number and plan information. **DON'T DELAY – ENROLL TODAY!** To avoid this delay we urge you to submit your application to us as soon as possible.

You should not cancel your current coverage until you are notified of your new coverage.

For verification of your new coverage, E-mail:

Enrollment@Benefitsstore.com

*This program is a special benefit for members of local REALTOR® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.

SafeGuard Dental HMO Enrollment Form

How to Enroll:

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator or SafeGuard. Choose a general dental office (facility) of your choice for each eligible family member from the SafeGuard directory of participating dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, SafeGuard will process your second selection.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire
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Subscriber's Information

Last Name		First Name		MI	Subscriber SS#	
Home Address						Apt. #
City			State		Zip Code	
Male/Female	Date of Birth	Home Telephone ()		Work Telephone ()		Ext.
1st Choice Dental Office #				2nd Choice Dental Office #		

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	1st Choice Dental Office #	2nd Choice Dental Office #

Primary language: _____ **Please note any communication impairment:** _____

Agreement - I understand that any dispute or controversy which may arise between SafeGuard and my Organization or between myself and SafeGuard Health Plans, Inc., must be submitted to binding arbitration in lieu of a jury or court trial. This may not apply in all states.

Authorization to release dental records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialist, to SafeGuard and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Florida residents only: Any person who knowingly and with intent to insure, defraud, or deceive any insurer files a statement or claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

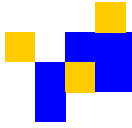
Your Name (Please Print)	Your Signature	Date
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Waiver of Coverage

I have been given the opportunity to apply for group dental insurance, but:

- Do not choose to elect this coverage.
- Am covered under spouse's dental plan with _____
Name of Insurance Company





Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information

Name:

Email:

Payment Selection

CCA [] EFT / ACH []

Credit Card Transaction

Credit Card Information: Visa [] Mastercard [] Discover [] American Express []

Card Number: Exp: (MM / YY):

Name (as appears on the card): Authorization Code:

Address: City: State: Zip:

Monthly Recurring Charges: I authorize the Benefits Store to charge this credit card for the monthly premium on the 20th of each month. Yes [] No [] Initials: ____

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

Name on Account: Name of Financial Institution:

Routing Number (9 digits): Account Number:

Account Holder Type: Personal [] Business [] Account Type: Checking [] Savings []

Determining your routing number:

To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Three diagrams showing check layouts for Bank 1, Bank 2, and Bank 3. Bank 1 shows routing #, check #, and account #. Bank 2 shows routing #, account #, and check #. Bank 3 shows check #, routing #, and account #. Each diagram includes fields for YOUR NAME, YOUR BANK, and a dollar amount.

I authorize the Benefits Store to deduct the monthly premium from this bank account.

Yes [] No [] Initials: ____ 5th of the Month [] 15th of the Month []

Monthly Recurring Charges (EFT)

Payment Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above. I will not hold The Benefits Store, Inc. responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository/credit institution.

Monthly Transactions Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to The Benefits Store, Inc. or upon the termination of the coverage through The Benefits Store, Inc. Should a rate change due to policy renewal, age band change or coverage tier occur, I authorize The Benefits Store, Inc. to automatically make the adjustment to my monthly deduction.

Note: I understand and authorize a \$25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature: Date:

Payment Amount: \$ _____

IMPORTANT NOTICE**NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS**

PHONE NUMBER: (888) 226-8373

FAX: (925) 855-2051

EMAIL: BILLING@BENEFITSSTORE.COM

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 238

Alamo, CA 94507

Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)

You may do a one time transaction or monthly deduction.

RELIABLE!

EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!

All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EFT MONTHLY PAYMENTS!

You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

SIMPLE!

Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

Monthly Invoice / Check

Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1st and payable (received) on or before June 20th.Late fees are charged for payments received after the 20th.Your full payment must be received by the 20th to avoid a late charge. We suggest that you mail your payment on or before the 12th of each monthPayments **MUST** be mailed to:**The Benefits Store, Inc.****P.O. Box 743322****Los Angeles, CA 90074-3322**To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.**On-Line Bill Payment**

Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service

www.Bankofamerica.com[B of A - Online Banking Info](#)www.Wellsfargo.com[Wells Fargo - Online Banking Information](#)Your full payment must be received by the 20th to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10th of each month.Payments **MUST** be mailed to:**The Benefits Store, Inc.****P.O. Box 743322****Los Angeles, CA 90074-3322**To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.**Credit Card Payment Visa or MasterCard**

Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site www.BenefitsStore.comTo do so, click on the "Forms" tab located in the bar crossing our home page or select the following link [Credit Card Authorization Form](#)Your full payment must be received by the 20th to avoid a late charge. We suggest you initiate your credit card payment on or before the 17th of each month.**For processing, Credit Card Authorization forms must be faxed to (925) 855-2051**Contact us at (888) 226-8373 with any questions about completing this form.



SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan*

SG150

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. SafeGuard is an affiliate of MetLife.

Specialty Care Information: During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your selected general dentist may refer you directly to a contracted SafeGuard specialty care provider for endodontics, oral surgery, orthodontics, periodontics, or pedodontics; no referral or preauthorization from SafeGuard is required.

* Prior authorization from SafeGuard is required for referrals to participating orthodontists and pediatric specialists. Your selected general dentist will submit all required documentation to SafeGuard and SafeGuard will advise you of the name, address and telephone number of a SafeGuard contracted orthodontist or pediatric specialist in your area.

Code	Service	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)		
D0210	Intraoral – complete series (including bitewings)	\$0
D0220	Intraoral – periapical first film	\$0
D0230	Intraoral – periapical each additional film	\$0
D0240	Intraoral – occlusal film	\$0
D0250	Extraoral – first film	\$0
D0260	Extraoral – each additional film	\$0
D0270	Bitewing – single film	\$0
D0272	Bitewings – two films	\$0
D0273	Bitewings – three films	\$0
D0274	Bitewings – four films	\$0
D0330	Panoramic film	\$0
D0350	Oral/facial photographic images	\$0
Tests and Examinations		
D0460	Pulp vitality tests	\$0

Code	Service	Co-payment
D0470	Diagnostic casts	\$0
	Preventive Services	
	<i>Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.</i>	
D1110	Prophylaxis – adult*	\$0
D1120	Prophylaxis – child*	\$0
D1203	Topical application of fluoride (prophylaxis not included) – child*	\$0
D1204	Topical application of fluoride (prophylaxis not included) – adult*	\$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients*	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$8
D1510	Space maintainer – fixed – unilateral	\$40
D1515	Space maintainer – fixed – bilateral	\$40
D1520	Space maintainer – removable – unilateral	\$40
D1525	Space maintainer – removable – bilateral	\$40
D1550	Recementation of space maintainer	\$5
D1555	Removal of fixed space maintainer	\$5
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	\$8
D2150	Amalgam – two surfaces, primary or permanent	\$12
D2160	Amalgam – three surfaces, primary or permanent	\$18
D2161	Amalgam – four or more surfaces, primary or permanent	\$18
D2330	Resin-based composite – one surface, anterior	\$8
D2331	Resin-based composite – two surfaces, anterior	\$12
D2332	Resin-based composite – three surfaces, anterior	\$18
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$28
D2390	Resin-based composite crown, anterior	\$30
D2391	Resin-based composite – one surface, posterior	\$65
D2392	Resin-based composite – two surfaces, posterior	\$75
D2393	Resin-based composite – three surfaces, posterior	\$80
D2394	Resin-based composite – four or more surfaces, posterior	\$80
	Crowns	
	<ul style="list-style-type: none"> ● <i>Replacement limit 1 every 5 years.</i> ● <i>An additional charge will be applied for any procedure using noble or high noble metal.</i> ● <i>Cases involving 7 or more crowns in the same treatment plan require additional \$125 member fee per unit in addition to co-pay.</i> ● <i>\$75 fee per crown unit above co-pay for porcelain on molars.</i> 	
D2510	Inlay – metallic – one surface	\$125
D2520	Inlay – metallic – two surfaces	\$125
D2530	Inlay – metallic – three or more surfaces	\$125
D2543	Onlay – metallic – three surfaces	\$150
D2544	Onlay – metallic – four or more surfaces	\$150
D2740	Crown – porcelain/ceramic substrate	\$225
D2750	Crown – porcelain fused to high noble metal	\$150

Code	Service	Co-payment
D2751	Crown – porcelain fused to predominantly base metal	\$150
D2752	Crown – porcelain fused to noble metal	\$150
D2780	Crown – ¾ cast high noble metal	\$150
D2781	Crown – ¾ cast predominantly base metal	\$150
D2782	Crown – ¾ cast noble metal	\$150
D2790	Crown – full cast high noble metal	\$150
D2791	Crown – full cast predominantly base metal	\$150
D2792	Crown – full cast noble metal	\$150
D2794	Crown – titanium	\$150
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	\$35
D2931	Prefabricated stainless steel crown – permanent tooth	\$35
D2940	Sedative filling	\$0
D2950	Core buildup, including any pins	\$15
D2951	Pin retention – per tooth, in addition to restoration	\$10
D2952	Post and core in addition to crown, indirectly fabricated	\$50
D2954	Prefabricated post and core in addition to crown	\$50
D2955	Post removal (not in conjunction with endodontic therapy)	\$10
D2970	Temporary crown (fractured tooth)	\$0
Endodontics		
<i>All procedures exclude final restoration.</i>		
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
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	Anterior (excluding final restoration)	\$100
D3320	Bicuspid (excluding final restoration)	\$110
D3330	Molar (excluding final restoration)	\$200
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$100
D3346	Retreatment of previous root canal therapy – anterior	\$110
D3347	Retreatment of previous root canal therapy – bicuspid	\$120
D3348	Retreatment of previous root canal therapy – molar	\$210
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3410	Apicoectomy/periradicular surgery – anterior	\$180
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$180
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$180
D3426	Apicoectomy/periradicular surgery (each additional root)	\$180

Code	Service	Co-payment
D3430	Retrograde filling – per root	\$180
D3450	Root amputation – per root	\$95
D3920	Hemisection (including any root removal), not including root canal therapy	\$90
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	\$75
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	\$56
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	\$325
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	\$244
D4249	Clinical crown lengthening – hard tissue	\$125
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	\$300
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	\$225
D4270	Pedicle soft tissue graft procedure	\$250
D4271	Free soft tissue graft procedure (including donor site surgery)	\$250
D4273	Subepithelial connective tissue graft procedures, per tooth	\$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$70
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$35
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$26
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$35
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$60
D4910	Periodontal maintenance (2 in a 12 month period)	\$35
Removable Prosthodontics		
<ul style="list-style-type: none"> ● <i>Relines are limited to 1 every 24 months.</i> ● <i>Includes up to 3 adjustments within 6 months of delivery.</i> 		
D5110	Complete denture – maxillary	\$175
D5120	Complete denture – mandibular	\$175
D5130	Immediate denture – maxillary	\$175
D5140	Immediate denture – mandibular	\$175
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$150
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$150
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$200
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$200
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	\$25

Code	Service	Co-payment
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$25
D5610	Repair resin denture base	\$25
D5620	Repair cast framework	\$25
D5630	Repair or replace broken clasp	\$25
D5640	Replace broken teeth – per tooth	\$25
D5650	Add tooth to existing partial denture	\$25
D5660	Add clasp to existing partial denture	\$25
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)	\$50
D5731	Reline complete mandibular denture (chairside)	\$50
D5740	Reline maxillary partial denture (chairside)	\$50
D5741	Reline mandibular partial denture (chairside)	\$50
D5750	Reline complete maxillary denture (laboratory)	\$50
D5751	Reline complete mandibular denture (laboratory)	\$50
D5760	Reline maxillary partial denture (laboratory)	\$50
D5761	Reline mandibular partial denture (laboratory)	\$50
D5820	Interim partial denture (maxillary)	\$50
D5821	Interim partial denture (mandibular)	\$50
D5850	Tissue conditioning, maxillary	\$10
D5851	Tissue conditioning, mandibular	\$10

Crowns/Fixed Bridges - Per Unit

- *Replacement limit 1 every 5 years.*
- *An additional charge will be applied for any procedure using noble or high noble metal.*
- *Cases involving 7 or more crowns in the same treatment plan require additional \$125 member fee per unit in addition to co-pay.*
- *\$75 fee per crown unit above co-pay for porcelain on molars.*

D6210	Pontic – cast high noble metal	\$150
D6211	Pontic – cast predominantly base metal	\$150
D6212	Pontic – cast noble metal	\$150
D6214	Pontic – titanium	\$150
D6240	Pontic – porcelain fused to high noble metal	\$150
D6241	Pontic – porcelain fused to predominantly base metal	\$150
D6242	Pontic – porcelain fused to noble metal	\$150
D6750	Crown – porcelain fused to high noble metal	\$150
D6751	Crown – porcelain fused to predominantly base metal	\$150
D6752	Crown – porcelain fused to noble metal	\$150
D6780	Crown – ¾ cast high noble metal	\$150
D6781	Crown – ¾ cast predominantly base metal	\$150
D6782	Crown – ¾ cast noble metal	\$150
D6790	Crown – full cast high noble metal	\$150
D6791	Crown – full cast predominantly base metal	\$150
D6792	Crown – full cast noble metal	\$150
D6794	Crown – titanium	\$150

Code	Service	Co-payment
D6930	Recement fixed partial denture	\$0
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$50
D6973	Core build up for retainer, including any pins	\$15
Oral Surgery		
<ul style="list-style-type: none"> • <i>Includes routine post operative visits/treatment.</i> • <i>Surgical removal of impacted teeth not covered unless pathology (disease) exists.</i> • <i>Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.</i> 		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$30
D7220	Removal of impacted tooth – soft tissue	\$50
D7230	Removal of impacted tooth – partially bony	\$100
D7240	Removal of impacted tooth – completely bony	\$125
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$130
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$110
D7280	Surgical access of an unerupted tooth	\$175
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
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$0
D7963	Frenuloplasty	\$0
D7971	Excision of pericoronal gingiva	\$40
Orthodontics		
<i>Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.</i>		
D8020	Limited orthodontic treatment of the transitional dentition	\$725
D8030	Limited orthodontic treatment of the adolescent dentition	\$725
D8040	Limited orthodontic treatment of the adult dentition	\$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1,695
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,695
D8090	Comprehensive orthodontic treatment of the adult dentition	\$1,695
D8660	Pre-orthodontic treatment visit	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$250
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	\$0

Code	Service	Co-payment
	<ul style="list-style-type: none"> • Orthodontic treatment plan and records (pre/post x-rays, photos, study models) 	\$250
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$0
D9120	Fixed partial denture sectioning	\$0
D9215	Local anesthesia	\$0
D9310	Consultation – diagnostic service provided by dentist or physician other	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$0
D9440	Office visit – after regularly scheduled hours	\$35
D9630	Other drugs and/or medicaments, by report	\$15
D9951	Occlusal adjustment – limited	\$0
D9952	Occlusal adjustment – complete	\$0
	<ul style="list-style-type: none"> • Broken appointment (less than 24 hour notice) 	\$10

Current Dental Terminology © American Dental Association

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 specialty care dentist, not contracted with SafeGuard, without prior approval by SafeGuard (except for out of area emergency services).
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
4. 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.
5. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
6. Orthognathic surgery.
7. General anesthesia or intravenous sedation.
8. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
9. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
10. Treatment of malignancies, cysts, or neoplasms.
11. 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.
12. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
13. Precision attachments.
14. 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.
15. 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.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. 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.

Exclusions and Limitations

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. Relines are limited to one every twenty four (24) months.
4. Full-mouth X-rays: Once every three (3) years, unless medically necessary.
5. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.
6. Dentures (full or partial): Replacement only after five (5) 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 contracted general dentist.
7. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
8. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
9. 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.
10. There is a \$75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
11. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
12. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
13. Surgical removal of impacted teeth is not a covered benefit unless pathology (disease) exists.
14. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist 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). Intercepting orthodontics;
 - e). Changes in treatment necessitated by an accident;
 - f). Treatment involving:
 - 1). Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
 - 2). Hormonal imbalances or other factors affecting growth or developmental abnormalities;
 - 3). Treatment related to temporomandibular joint disorders;
 - 4). Lingually placed direct bonded appliances and arch wires ("invisible braces"); and
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

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**。