SCHEDULE OF BENEFITS

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

DIRECT REFERRAL DENTAL PLAN MET335-TX-HCR

This SCHEDULE OF BENEFITS lists the Covered Services available to you under your dental plan, as well as the 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. Your Selected General Dentist is responsible for determining when the services of a Specialty Care Dentist are needed, and facilitating any necessary referral. You will be advised of the name, address and telephone number of the Specialty Care Dentist your Service Area.

Missed Appointments: If you need 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. If you fail to do this in a timely fashion, you may be charged a missed appointment fee.

Out-of-Pocket Maximums

Individual Out-of-Pocket Annual Maximum	
• In-Network.....	$350, for one child under age 19
• Out-of-Network.....	None
Family Out-of-Pocket Annual Maximum	
• In-Network.....	$700, for 2 or more children under age 19
• Out-of-Network.....	None

The Covered Person's out-of-pocket annual maximum includes the Covered Person's Co-Payments for Covered Services provided by the Selected General Dentist or Specialty Care Dentist. The out-of-pocket annual maximum does not include the Covered Person's Co-Payments for: (1) non-medically necessary Orthodontia, (2) services that are not Covered Services or (3) services that are in addition to the Essential Health Benefits as identified by the state of Texas.

	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
•	Office visit - per visit (including all fees for sterilization and/or infection control)	$5	$5

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	Diagnostic Treatment		
D0120	Periodic oral evaluation - established patient	$0	$0
D0140	Limited oral evaluation - problem focused	$0	$0
D0145	Oral evaluation for a patient under three years of age and counseling	$0	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	with primary caregiver		
D0150	Comprehensive oral evaluation - new or established patient	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	$0
D0171	Re-evaluation – post-operative office visit	$0	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0	$0
D0190	Screening of a patient	$0	$0
D0191	Assessment of a patient	$0	$0
	Radiographs / Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series of radiographic images	$0	$0
D0220	Intraoral – periapical first radiographic image	$0	$0
D0230	Intraoral – periapical each additional radiographic image	$0	$0
D0240	Intraoral – occlusal radiographic image	$0	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0	$0
D0251	Extra-oral posterior dental radiographic image	$0	$0
D0270	Bitewing – single radiographic image	$0	$0
D0272	Bitewings – two radiographic images	$0	$0
D0273	Bitewings – three radiographic images	$0	$0
D0274	Bitewings – four radiographic images	$0	$0
D0277	Vertical bitewings – 7 to 8 radiographic images	$0	$0
D0330	Panoramic radiographic image	$0	$0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$0	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0	$0
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	$180	$180
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	$180	$180
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	$180	$180
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	$180	$180
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	$180	$180
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	$180	$180
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	$180	$180

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	$180	$180
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$0	$0
	Tests and Examinations		
D0415	Collection of microorganisms for culture and sensitivity	$0	$0
D0425	Caries susceptibility tests	$0	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50	$50
D0460	Pulp vitality tests	$0	$0
D0470	Diagnostic casts	$0	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0	$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	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$0	$0
D0502	Other oral pathology procedures, by report	$0	$0
	Preventive Services		
D1110	Prophylaxis – adult	$5	$5
•	Additional-adult prophylaxis (maximum of 2 additional per year)	$45	$35
D1120	Prophylaxis – child	$5	$5
•	Additional-child prophylaxis (maximum of 2 additional per year)	$35	$25
D1206	Topical application of fluoride varnish	$0	$0
D1208	2D oral/facial photographic image obtained intra-orally or extra-orally	$0	$0
D1310	Nutritional counseling for control of dental disease	$0	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0	$0
D1330	Oral hygiene instructions	$0	$0
•	Includes periodontal hygiene instruction		
D1351	Sealant – per tooth	$0	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0	$0
D1353	Sealant repair - per tooth	$0	$0
D1354	Interim caries arresting medicament application – per tooth	$0	$0

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D1510	Space maintainer – fixed, unilateral – per quadrant Excludes a distal shoe space maintainer	$25	$25
D1516	Space maintainer – fixed – bilateral, maxillary	$25	$25
D1517	Space maintainer – fixed – bilateral, mandibular	$25	$25
D1520	Space maintainer – removable, unilateral – per quadrant	$35	$35
D1526	Space maintainer – removable – bilateral, maxillary	$35	$35
D1527	Space maintainer – removable – bilateral, mandibular	$35	$35
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$18	$18
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$18	$18
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$18	$18
D1556	Removal of fixed unilateral space maintainer – per quadrant	$18	$18
D1557	Removal of fixed bilateral space maintainer – maxillary	$18	$18
D1558	Removal of fixed bilateral space maintainer – mandibular	$18	$18
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliance, once the tooth had erupted	$25	$25
	Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	$12	$12
D2150	Amalgam – two surfaces, primary or permanent	$20	$20
D2160	Amalgam – three surfaces, primary or permanent	$23	$23
D2161	Amalgam – four or more surfaces, primary or permanent	$25	$25
D2330	Resin-based composite – one surface, anterior	$12	$12
D2331	Resin-based composite – two surfaces, anterior	$20	$20
D2332	Resin-based composite – three surfaces, anterior	$23	$23
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$25	$25
D2390	Resin-based composite crown, anterior	$30	$30
D2391	Resin-based composite – one surface, posterior	$30	$30
D2392	Resin-based composite – two surfaces, posterior	$45	$45
D2393	Resin-based composite – three surfaces, posterior	$65	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65	$65
	Crowns		

- *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.*
- *Cases involving seven (7) or more Crowns, implants 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, implant or Bridge unit.*

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D2510	Inlay – metallic – one surface	$310	$310
D2520	Inlay – metallic – two surfaces	$310	$310
D2530	Inlay – metallic – three or more surfaces	$310	$310
D2542	Onlay – metallic – two surfaces	$310	$310
D2543	Onlay – metallic – three surfaces	$310	$310
D2544	Onlay – metallic – four or more surfaces	$310	$310
D2610	Inlay – porcelain/ceramic – one surface	$335	$335
D2620	Inlay – porcelain/ceramic – two surfaces	$335	$335
D2630	Inlay – porcelain/ceramic – three or more surfaces	$335	$335
D2642	Onlay – porcelain/ceramic – two surfaces	$335	$335
D2643	Onlay – porcelain/ceramic – three surfaces	$335	$335
D2644	Onlay – porcelain/ceramic – four or more surfaces	$335	$335
D2650	Inlay – resin-based composite – one surface	$335	$335
D2651	Inlay – resin-based composite – two surfaces	$335	$335
D2652	Inlay – resin-based composite – three or more surfaces	$335	$335
D2662	Onlay – resin-based composite – two surfaces	$335	$335
D2663	Onlay – resin-based composite – three surfaces	$335	$335
D2664	Onlay – resin-based composite – four or more surfaces	$335	$335
D2710	Crown – resin-based composite (indirect)	$335	$335
D2712	Crown – ¾ resin-based composite (indirect)	$335	$335
D2720	Crown – resin with high noble metal	$335	$335
D2721	Crown – resin with predominantly base metal	$335	$335
D2722	Crown – resin with noble metal	$335	$335
D2740	Crown – porcelain/ceramic	$360	$360
D2750	Crown – porcelain fused to high noble metal	$335	$335
D2751	Crown – porcelain fused to predominantly base metal	$335	$335
D2752	Crown – porcelain fused to noble metal	$335	$335
D2753	Crown – porcelain fused to titanium and titanium alloys	$335	$335
D2780	Crown – ¾ cast high noble metal	$335	$335
D2781	Crown – ¾ cast predominantly base metal	$335	$335
D2782	Crown – ¾ cast noble metal	$335	$335
D2783	Crown – ¾ porcelain/ceramic	$335	$335
D2790	Crown – full cast high noble metal	$335	$335
D2791	Crown – full cast predominantly base metal	$335	$335
D2792	Crown – full cast noble metal	$335	$335
D2794	Crown – titanium and titanium alloys	$335	$335
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$100	$100

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0	$0
D2920	Re-cement or re-bond crown	$0	$0
D2930	Prefabricated stainless steel crown – primary tooth	$25	$25
D2931	Prefabricated stainless steel crown – permanent tooth	$25	$25
D2932	Prefabricated resin crown	$45	$45
D2933	Prefabricated stainless steel crown with resin window	$45	$45
D2940	Protective restoration	$0	$0
D2941	Interim therapeutic restoration - primary dentition	$0	$0
D2950	Core buildup, including any pins when required	$75	$75
D2951	Pin retention – per tooth, in addition to restoration	$10	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50	$50
D2953	Each additional indirectly fabricated post – same tooth	$50	$50
D2954	Prefabricated post and core in addition to crown	$30	$30
D2955	Post removal	$10	$10
D2957	Each additional prefabricated post – same tooth	$30	$30
D2960	Labial veneer (resin laminate) – chairside	$250	$250
D2961	Labial veneer (resin laminate) – laboratory	$300	$300
D2962	Labial veneer (porcelain laminate) – laboratory	$350	$350
D2971	Additional procedures to construct new crown under existing partial denture framework	$50	$50
D2980	Crown repair necessitated by restorative material failure	$0	$0
D2981	Inlay repair necessitated by restorative material failure	$0	$0
D2982	Onlay repair necessitated by restorative material failure	$0	$0
D2983	Veneer repair necessitated by restorative material failure	$0	$0
D2990	Resin infiltration of incipient smooth surface lesions	$0	$0
	Endodontics		
•	*All procedures exclude final restoration.*		
D3110	Pulp cap – direct (excluding final restoration)	$5	$5
D3120	Pulp cap – indirect (excluding final restoration)	$5	$5
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$40	$40
D3221	Pulpal debridement, primary and permanent teeth	$55	$55
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$40	$40
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$40	$40

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$40	$40
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$130	$130
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$215	$215
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$305	$305
D3331	Treatment of root canal obstruction; non-surgical access	$85	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$130	$130
D3333	Internal root repair of perforation defects	$85	$85
D3346	Retreatment of previous root canal therapy – anterior	$265	$265
D3347	Retreatment of previous root canal therapy – premolar	$325	$325
D3348	Retreatment of previous root canal therapy – molar	$375	$375
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$80	$80
D3352	Apexification/recalcification – interim medication replacement	$80	$80
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$80	$80
D3355	Pulpal regeneration - initial visit	$80	$80
D3356	Pulpal regeneration - interim medication replacement	$40	$40
D3357	Pulpal regeneration - completion of treatment	$80	$80
D3410	Apicoectomy – anterior	$95	$95
D3421	Apicoectomy – premolar (first root)	$95	$95
D3425	Apicoectomy – molar (first root)	$95	$95
D3426	Apicoectomy (each additional root)	$80	$80
D3427	Periradicular surgery without apicoectomy	$71	$70
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$180	$180
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$95	$95
D3430	Retrograde filling – per root	$70	$70
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$95	$95
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	$215	$215
D3450	Root amputation – per root	$110	$110
D3460	Endodontic endosseous implant	$555	$555
D3910	Surgical procedure for isolation of tooth with rubber dam	$0	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$90	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15	$15

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	Periodontics		
•	*Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Us.*		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$150	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$100	$100
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$30	$30
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$170	$170
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$130	$130
D4245	Apically positioned flap	$165	$165
D4249	Clinical crown lengthening – hard tissue	$160	$160
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$330	$330
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$286	$286
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$180	$180
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$95	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95	$95
D4266	Guided tissue regeneration – resorbable barrier, per site	$215	$215
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	$255	$255
D4268	Surgical revision procedure, per tooth	$0	$0
D4270	Pedicle soft tissue graft procedure	$250	$250
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$115	$115
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$75	$75
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$260	$260
D4278	Free soft tissue graft procedure (including recipient and donor	$130	$130

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site		
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$38	$38
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$190	$190
D4320	Provisional splinting – intracoronal	$95	$95
D4321	Provisional splinting – extracoronal	$85	$85
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$60	$60
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$45	$45
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$5	$5
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$60	$60
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$65	$65
D4910	Periodontal maintenance	$45	$45
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0	$0
•	Additional periodontal maintenance procedures (beyond 2 per 12 months)	$55	$55
	Removable Prosthodontics		
•	*Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service.*		
D5110	Complete denture – maxillary	$505	$505
D5120	Complete denture – mandibular	$505	$505
D5130	Immediate denture – maxillary	$505	$505
D5140	Immediate denture – mandibular	$505	$505
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$405	$405
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$465	$465
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$550	$550
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$550	$550
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s)	$405	$405

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s)	$465	$465
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s)	$550	$550
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s)	$550	$550
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$550	$550
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$550	$550
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$360	$360
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$360	$360
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	$180	$180
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$180	$180
D5410	Adjust complete denture – maxillary	$20	$20
D5411	Adjust complete denture – mandibular	$20	$20
D5421	Adjust partial denture – maxillary	$20	$20
D5422	Adjust partial denture – mandibular	$20	$20
D5511	Repair broken complete denture base, mandibular	$50	$50
D5512	Repair broken complete denture base, maxillary	$50	$50
D5520	Replace missing or broken teeth – complete denture (each tooth)	$40	$40
D5611	Repair resin partial denture base, mandibular	$50	$50
D5612	Repair resin partial denture base, maxillary	$50	$50
D5621	Repair cast partial framework, mandibular	$50	$50
D5622	Repair cast partial framework, maxillary	$50	$50
D5630	Repair or replace broken retentive clasping materials – per tooth	$70	$70
D5640	Replace broken teeth – per tooth	$40	$40
D5650	Add tooth to existing partial denture	$60	$60
D5660	Add clasp to existing partial denture - per tooth	$70	$70
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165	$165
D5710	Rebase complete maxillary denture	$125	$125
D5711	Rebase complete mandibular denture	$125	$125

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D5720	Rebase maxillary partial denture	$125	$125
D5721	Rebase mandibular partial denture	$125	$125
D5730	Reline complete maxillary denture (chairside)	$100	$100
D5731	Reline complete mandibular denture (chairside)	$100	$100
D5740	Reline maxillary partial denture (chairside)	$90	$90
D5741	Reline mandibular partial denture (chairside)	$90	$90
D5750	Reline complete maxillary denture (laboratory)	$130	$130
D5751	Reline complete mandibular denture (laboratory)	$130	$130
D5760	Reline maxillary partial denture (laboratory)	$130	$130
D5761	Reline mandibular partial denture (laboratory)	$130	$130
D5810	Interim complete denture (maxillary)	$230	$230
D5811	Interim complete denture (mandibular)	$230	$230
D5820	Interim partial denture (maxillary)	$160	$160
D5821	Interim partial denture (mandibular)	$170	$170
D5850	Tissue conditioning, maxillary	$40	$40
D5851	Tissue conditioning, mandibular	$40	$40
D5862	Precision attachment, by report	$160	$160
D5876	Add metal substructure to acrylic full denture (per arch)	$127	$127
	Implant Services		
	Pre-Surgical Services		
D6190	Radiographic/surgical implant index, by report	$130	$130
	Surgical Services		
D6010	Surgical placement of implant body: endosteal implant	$1,005	$1,005
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$770	$770
D6013	Surgical placement of mini implant	$1,005	$1,005
D6040	Surgical placement: eposteal implant	$1,860	$1,860
D6050	Surgical placement: transosteal implant	$1,170	$1,170
D6051	Interim abutment	$123	$123
D6052	Semi-precision attachment abutment	$335	$335
D6096	Remove broken implant retaining screw	$24	$24
D6100	Implant removal, by report	$240	$240
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$39	$39
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$86	$86
D6103	Bone graft for repair of peri-implant defect – does not include flap		

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	entry and closure	$100	$100
D6104	Bone graft at time of implant placement	$100	$100
	Implant Supported Prosthetics		
•	*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.*		
•	*Cases involving seven (7) or more Crowns, implants 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, implant or Bridge unit.*		
D6055	Connecting bar – implant supported or abutment supported	$345	$345
D6056	Prefabricated abutment – includes modification and placement	$245	$245
D6057	Custom fabricated abutment – includes placement	$335	$335
D6058	Abutment supported porcelain/ceramic crown	$685	$685
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$660	$660
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$640	$640
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$645	$645
D6062	Abutment supported cast metal crown (high noble metal)	$655	$655
D6063	Abutment supported cast metal crown (predominantly base metal)	$640	$640
D6064	Abutment supported cast metal crown (noble metal)	$720	$720
D6065	Implant supported porcelain/ceramic crown	$725	$725
D6066	Implant supported crown – porcelain fused to high noble alloys A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant	$700	$700
D6067	Implant supported crown – high noble alloys A single metal crown restoration that is retained, supported and stabilized by an implant	$725	$725
D6068	Abutment supported retainer for porcelain/ceramic FPD	$680	$680
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$680	$680
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$595	$595
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$635	$635
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$625	$625
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$445	$445
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$640	$640
D6075	Implant supported retainer for ceramic FPD	$720	$720
D6076	Implant supported retainer for FPD – porcelain fused to high noble alloys A metal-ceramic retainer for a fixed partial denture that gains	$700	$700

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	retention, support and stability from an implant		
D6077	Implant supported retainer for metal FPD – high noble alloys A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	$510	$510
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	$55	$55
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$20	$20
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$640	$640
D6083	Implant supported crown – porcelain fused to noble alloys	$645	$645
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$650	$650
D6086	Implant supported crown – predominantly base alloys	$640	$640
D6087	Implant supported crown – noble alloys	$720	$720
D6088	Implant supported crown – titanium and titanium alloys	$650	$650
D6090	Repair implant supported prosthesis, by report	$190	$190
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$170	$170
D6092	Re-cement or re-bond implant/abutment supported crown	$50	$50
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$70	$70
D6094	Abutment supported crown – titanium and titanium alloys A single crown restoration that is retained, supported and stabilized by an abutment on an implant	$650	$650
D6095	Repair implant abutment, by report	$140	$140
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$700	$700
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$595	$595
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	$635	$635
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	$995	$995
D6111	Implant/abutment supported removable denture for edentulous arch-mandibular	$995	$995
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	$945	$945
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	$945	$945
D6114	Implant/abutment supported fixed denture for edentulous arch-maxillary	$2,380	$2,380
D6115	Implant/abutment supported fixed denture for edentulous arch-	$2,380	$2,380

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	mandibular		
D6116	Implant/abutment supported fixed denture for partially edentulous arch-maxillary	$1,410	$1,410
D6117	Implant/abutment supported fixed denture for partially edentulous arch-mandibular	$1,410	$1,410
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$520	$520
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$445	$445
D6122	Implant supported retainer for metal FPD – noble alloys	$640	$640
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$520	$520
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys. A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant	$520	$520
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	$510	$510
	Crowns/Fixed Bridges - Per Unit		
•	*An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 Co-Payment per molar, for the use of porcelain.*		
•	*Cases involving seven (7) or more Crowns, implants 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, implant or Bridge unit.*		
D6205	Pontic – indirect resin based composite	$310	$310
D6210	Pontic – cast high noble metal	$335	$335
D6211	Pontic – cast predominantly base metal	$335	$335
D6212	Pontic – cast noble metal	$335	$335
D6214	Pontic – titanium and titanium alloys	$335	$335
D6240	Pontic – porcelain fused to high noble metal	$335	$335
D6241	Pontic – porcelain fused to predominantly base metal	$335	$335
D6242	Pontic – porcelain fused to noble metal	$335	$335
D6243	Pontic – porcelain fused to titanium and titanium alloys	$335	$335
D6245	Pontic – porcelain/ceramic	$360	$360
D6250	Pontic – resin with high noble metal	$335	$335
D6251	Pontic – resin with predominantly base metal	$335	$335
D6252	Pontic – resin with noble metal	$335	$335
D6253	Provisional pontic – further treatment or completion of diagnosis necessary prior to final impression	$100	$100
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$140	$140
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$140	$140

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D6549	Resin retainer-for resin bonded fixed prosthesis	$105	$105
D6600	Retainer inlay – porcelain/ceramic, two surfaces	$335	$335
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$335	$335
D6602	Retainer inlay – cast high noble metal, two surfaces	$335	$335
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$335	$335
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$335	$335
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$335	$335
D6606	Retainer inlay – cast noble metal, two surfaces	$335	$335
D6607	Retainer inlay – cast noble metal, three or more surfaces	$335	$335
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$335	$335
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$335	$335
D6610	Retainer onlay – cast high noble metal, two surfaces	$335	$335
D6611	Retainer onlay – cast high noble metal, three or more surfaces	$335	$335
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$335	$335
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$335	$335
D6614	Retainer onlay – cast noble metal, two surfaces	$335	$335
D6615	Retainer onlay – cast noble metal, three or more surfaces	$335	$335
D6624	Retainer inlay – titanium	$335	$335
D6634	Retainer onlay – titanium	$335	$335
D6710	Retainer crown – indirect resin based composite	$335	$335
D6720	Retainer crown – resin with high noble metal	$335	$335
D6721	Retainer crown – resin with predominantly base metal	$335	$335
D6722	Retainer crown – resin with noble metal	$335	$335
D6740	Retainer crown – porcelain/ceramic	$335	$335
D6750	Retainer crown – porcelain fused to high noble metal	$335	$335
D6751	Retainer crown – porcelain fused to predominantly base metal	$335	$335
D6752	Retainer crown – porcelain fused to noble metal	$335	$335
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$335	$335
D6780	Retainer crown – ¾ cast high noble metal	$335	$335
D6781	Retainer crown – ¾ cast predominantly base metal	$335	$335
D6782	Retainer crown – ¾ cast noble metal	$335	$335
D6783	Retainer crown – ¾ porcelain/ceramic	$335	$335
D6784	Retainer crown ¾ – titanium and titanium alloys	$335	$335
D6790	Retainer crown – full cast high noble metal	$335	$335
D6791	Retainer crown – full cast predominantly base metal	$335	$335
D6792	Retainer crown – full cast noble metal	$335	$335

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D6793	Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression	$100	$100
D6794	Retainer crown – titanium and titanium alloys	$335	$335
D6930	Re-cement or re-bond fixed partial denture	$0	$0
D6940	Stress breaker	$110	$110
D6950	Precision attachment	$195	$195
D6980	Fixed partial denture repair necessitated by restorative material failure	$45	$45
	Oral Surgery		
•	*Includes routine post operative visits/treatment.*		
•	*The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists.*		
D7111	Extraction, coronal remnants – primary tooth	$5	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5	$5
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$50	$50
D7220	Removal of impacted tooth – soft tissue	$60	$60
D7230	Removal of impacted tooth – partially bony	$65	$65
D7240	Removal of impacted tooth – completely bony	$135	$135
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$150	$150
D7250	Removal of residual tooth roots (cutting procedure)	$45	$45
D7251	Coronectomy – intentional partial tooth removal	$135	$135
D7260	Oroantral fistula closure	$270	$270
D7261	Primary closure of a sinus perforation	$275	$275
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80	$80
D7280	Exposure of an unerupted tooth	$115	$115
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90	$90
D7283	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	$90	$90
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$150	$150
D7286	Incisional biopsy of oral tissue – soft	$60	$60
D7287	Exfoliative cytological sample collection	$50	$50
D7288	Brush biopsy – transepithelial sample collection	$50	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45	$45
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or	$25	$25

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	tooth spaces, per quadrant		
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$190	$190
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$65	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$370	$370
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$990	$990
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$130	$130
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$335	$335
D7471	Removal of lateral exostosis (maxilla or mandible)	$80	$80
D7472	Removal of torus palatinus	$60	$60
D7473	Removal of torus mandibularis	$60	$60
D7485	Reduction of osseous tuberosity	$60	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$40	$40
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$40	$40
D7520	Incision and drainage of abscess – extraoral soft tissue	$40	$40
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$40	$40
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$505	$505
D7910	Suture of recent small wounds up to 5 cm	$30	$30
D7921	Collection and application of autologous blood concentrate product	$95	$95
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	$600	$600
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$825	$825
D7952	Sinus augmentation via a vertical approach	$825	$825
D7953	Bone replacement graft for ridge preservation – per site	$100	$100
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	$105	$105
D7963	Frenuloplasty	$105	$105
D7970	Excision of hyperplastic tissue – per arch	$55	$55
D7971	Excision of pericoronal gingiva	$45	$45
D7972	Surgical reduction of fibrous tuberosity	$125	$125
	Orthodontics		
•	*Both medically necessary and non-medically necessary Orthodontia*		

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
	is a Covered Service. Co-Payments made toward medically necessary Orthodontia are included in the Out-of-Pocket maximum for children under age 19.		
	• *For orthodontia services, We strongly recommend that you get a pretreatment estimate of proposed orthodontic services and then discuss that estimate with your SafeGuard selected general dentist or specialty care 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 at (800) 880-1800 to request a pretreatment estimate.*		
	• *Benefits cover twenty-four (24) months of usual & customary Orthodontic treatment and an additional twenty-four (24) months of retention.*		
	• *Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances.*		
D8010	Limited orthodontic treatment of the primary dentition	$1,260	$1,260
D8020	Limited orthodontic treatment of the transitional dentition	$1,260	$1,260
D8030	Limited orthodontic treatment of the adolescent dentition	$1,260	$1,260
D8040	Limited orthodontic treatment of the adult dentition	$1,260	$1,260
D8050	Interceptive orthodontic treatment of the primary dentition	*	$1,260
D8060	Interceptive orthodontic treatment of the transitional dentition	*	$1,260
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,410	$2,410
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,410	$2,410
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,410	$2,410
D8210	Removable appliance therapy	*	$300
D8220	Fixed appliance therapy	*	$300
D8660	Pre-orthodontic treatment examination to monitor growth and development	$40	$40
D8670	Periodic orthodontic treatment visit	$40	$40
D8681	Removable orthodontic retainer adjustment	$345	$345
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$345	$345
	• There is a Co-Payment of $250 for Orthodontic treatment planning and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models).		
	• There is a Co-Payment of $25 per visit for Orthodontic visits beyond twenty-four (24) months of active treatment or retention.		
D8698	Re-cement or re-bond fixed retainer – maxillary	$0	$0
D8699	Re-cement or re-bond fixed retainer – mandibular	$0	$0
D8701	Repair of fixed retainer, includes reattachment – maxillary	$0	$0

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D8702	Repair of fixed retainer, includes reattachment – mandibular	$0	$0
	Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$10	$10
D9120	Fixed partial denture sectioning	$0	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0	$0
D9211	Regional block anesthesia	$0	$0
D9212	Trigeminal division block anesthesia	$0	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	$60	$60
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$60	$60
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	$15
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$60	$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$60	$60
D9248	Non-intravenous conscious sedation	$15	$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	$0
D9311	Consultation with a medical health care professional	$0	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0	$0
D9440	Office visit – after regularly scheduled hours	$35	$35
D9450	Case presentation, detailed and extensive treatment planning	$0	$0
D9610	Therapeutic parenteral drug, single administration	$15	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25	$25
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$15	$15
D9630	Drugs or medicaments dispensed in the office for home use	$15	$15
D9910	Application of desensitizing medicament	$15	$15
D9930	Treatment of complication (post-surgical) – unusual circumstances, by report	$0	$0
D9932	Cleaning and inspection of removable complete denture, maxillary	$55	$55
D9933	Cleaning and inspection of removable complete denture, mandibular	$55	$55
D9934	Cleaning and inspection of removable partial denture, maxillary	$55	$55
D9935	Cleaning and inspection of removable partial denture, mandibular	$55	$55

*** -- Service Not Covered**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-Payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under Age 19
D9942	Repair and/or reline of occlusal guard	$40	$40
D9943	Occlusal guard adjustment	$10	$10
D9944	Occlusal guard – hard appliance, full arch	$85	$85
D9945	Occlusal guard – soft appliance, full arch	$85	$85
D9946	Occlusal guard – hard appliance, partial arch	$64	$64
D9951	Occlusal adjustment – limited	$35	$35
D9952	Occlusal adjustment – complete	$115	$115
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0	$0

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DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

FOR COVERED PERSONS OTHER THAN CHILDREN UNDER AGE 19:

General

1. Specialty Care Dentists will accept the contracted fee for all Covered Services.

2. 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 necessary by the Selected General Dentist or Specialty Care Dentist.

3. Sterilization and infection control are not billable to Us or You 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 (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.

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

Preventive

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

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

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

Restorative Treatment
Crowns, Implants and Fixed Bridges

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

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

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

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

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

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

6. 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.

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

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

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

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

Prosthodontics

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

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

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

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

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

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

7. Provisional 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.

Implant Services

1. Implants are limited to no more than once for the same tooth position in a five (5) year period.

2. Repairs of implants are limited to not more than once in a twelve (12) month period.

3. Implant supported prosthetics are limited to no more than once for the same tooth position in a five (5) year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

4. The following are limited to no more than two (2) each per year: Implants, Implant supported prosthetics, and Implant abutments.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

Endodontics

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

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

Oral Surgery

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

2. Includes routine post operative visits/treatments.

Periodontics

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

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

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

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

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

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

Orthodontics

1. If You or Your Dependent require the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.

2. If You or Your Dependent terminate coverage from the SafeGuard Plan after the start of Orthodontic treatment, You will be responsible for any additional charges incurred for the remaining Orthodontic treatment.

3. 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.

4. 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.

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

6. If You or Your Dependent started orthodontic treatment before Your coverage for Yourself or that Dependent started under this group contract, Continuing Orthodontic treatment is available under this group contract for You or Your Dependent under any of the following circumstances:

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

a. You were covered under the terms of a dental plan provided by SafeGuard and, due to an acquisition, are now covered under the terms of this group contract;

b. You were covered under the terms of a dental plan provided by a carrier other than SafeGuard and are now covered under the terms of this group contract because the Contract holder subsequently contracts with SafeGuard;

c. You become eligible for DHMO benefits under the terms of this group contract because of Your status as a new employee; or

d. You were covered under the terms of a dental plan and received orthodontic services which were not covered because that dental plan did not offer orthodontic coverage.

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 group contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS.

Continuing Orthodontic treatment will be available if You enroll within 30 days of the date You become eligible for benefits under the terms of this group contract.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

FOR CHILDREN UNDER AGE 19:

General

1. Specialty Care Dentists will accept the contracted fee for all Covered Services.

2. 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 necessary by the Selected General Dentist or Specialty Care Dentist.

3. Sterilization and infection control are not billable to Us or You 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 (including bitewings): once every three (3) years, unless Necessary for a specific dental problem.

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

Preventive

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

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

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

Restorative Treatment, Crowns, Bridges, Fixed Bridges

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

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

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

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

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

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

6. 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.

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

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

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

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

Prosthodontics

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

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

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

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

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

6. 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.

Implants

1. Implants are limited to no more than once for the same tooth position in a five (5) year period.

2. Repairs of implants are limited to not more than once in a twelve (12) month period.

3. Implant supported prosthetics are limited to no more than once for the same tooth position in a five (5) year period:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth.

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.

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

Oral Surgery

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

2. Includes routine post operative visits/treatments.

Periodontics

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

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

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

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

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

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

Orthodontics

1. If Your Dependent requires the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.

2. If Your Dependent terminates coverage from the SafeGuard Plan after the start of Orthodontic treatment, You will be responsible for any additional charges incurred for the remaining Orthodontic treatment.

3. 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.

4. 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.

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

6. If You or Your Dependent started orthodontic treatment before Your coverage for Yourself or that Dependent started under this group contract, Continuing Orthodontic treatment is available under this group contract for You or Your Dependent under any of the following circumstances:

    a. You were covered under the terms of a dental plan provided by SafeGuard and, due to an acquisition, are now covered under the terms of this group contract;

    b. You were covered under the terms of a dental plan provided by a carrier other than SafeGuard and are now covered under the terms of this group contract because the Contract holder subsequently contracts with SafeGuard;

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES (continued)

c. You become eligible for DHMO benefits under the terms of this group contract because of Your status as a new employee; or

d. You were covered under the terms of a dental plan and received orthodontic services which were not covered because that dental plan did not offer orthodontic coverage.

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 group contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS.

Continuing Orthodontic treatment will be available if You enroll within 30 days of the date You become eligible for benefits under the terms of this group contract.

DENTAL BENEFITS: EXCLUSIONS

FOR COVERED PERSONS OTHER THAN CHILDREN UNDER AGE 19:

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS), are not covered.

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

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

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

5. Orthognathic surgery.

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

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

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

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

10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

11. Dental services required while serving in the armed forces of any country or international authority.

12. Dental services considered Experimental or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.

13. Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.
14. The following are not included as Orthodontic benefits:

    a. Repair or replacement of lost or broken appliances;
    b. Retreatment of Orthodontic cases;
    c. Treatment involving:
        i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;

ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
iii. Treatment related to temporomandibular joint disorders;
iv. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.

d. Invisalign services are excluded.

DENTAL BENEFITS: EXCLUSIONS (continued)

FOR CHILDREN UNDER AGE 19:

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS), are not covered.

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

3. Any service which is not Dentally Necessary and/or medically necessary.

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

5. Orthognathic surgery.

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

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

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

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

10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

11. Dental services required while serving in the armed forces of any country or international authority.

12. Dental services considered Experimental or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.

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

14. The following are not included as Orthodontic benefits:

    A. Repair or replacement of lost or broken appliances;
    B. Retreatment of Orthodontic cases;
    C. Treatment involving:
        i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
        ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
        iii. Treatment related to temporomandibular joint disorders;
        iv. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
    D. Invisalign services are excluded.

LANGUAGE ASSISTANCE PROGRAM: NOTICE TO INSUREDS

If you, or someone you're helping, have questions about the MetLife Pediatric Dental Essential Health Benefit Plan, you have the right to get help and information in your language at no cost. To arrange for language assistance services, call (800) 880-1800.

Si usted, o alguien que está ayudando, tiene preguntas sobre MetLife Pediatric Dental Essential Health Benefit Plan (Plan de Beneficios de Salud de MetLife Odontología Pediátrica Esencial), usted tiene el derecho a obtener ayuda e información en su idioma sin costo alguno. Para coordinar los servicios de ayuda con el idioma, llame al (800) 880-1800.

如果您或您提供协助的某人有关于MetLife Pediatric Dental Essential Health Benefit Plan（大都会人寿小儿牙科基本健康福利计划）的问题，您有权免费获得以您的母语提供的帮助和信息。要安排语言协助服务，请致电（800）880-1800。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về MetLife Pediatric Dental Essential Health Benefit Plan (Chương Trình Phúc Lợi Y Tế Thiết Yếu Nha Khoa Trẻ Em của Metlife), quý vị có quyền nhận miễn phí trợ giúp và thông tin theo ngôn ngữ của quý vị. Để sắp xếp cho các dịch vụ hỗ trợ ngôn ngữ, xin gọi số (800) 880-1800.

귀하 또는 귀하께서 돕고 있는 누군가가MetLife Pediatric Dental Essential Health Benefit Plan (메트라이프 필수 소아 치과 건강보험)에 관해서 궁금해 한다면, 귀하께서는 귀하의 언어로 무료로 도움과 정보를 제공 받으실 권리가 있습니다. 언어 통역 서비스를 이용하시려면 (800) 880-1800으로 전화하십시오.

إذا كنت لديك أنت أو الشخص الذي تساعده أي سؤال بخصوص MetLife Pediatric Dental Essential Health Benefit Plan (خطة ميتلايف الأساسية للمزايا الصحية لأسنان الأطفال)، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. لترتيب خدمات المساعدة بلغتك، الرجاء الاتصال على الرقم 1800-880 (800).

Si ou, oubyen yon moun w ap ede, genyen kesyon sou MetLife Pediatric Dental Essential Health Benefit Plan (Plan Benefis Sante Dantè Esansyèl Pedyatri MetLife) ou gen dwa resevwa èd ak enfòmasyon nan pwòp lang paw san peye anyen. Pou aranjman asistans sèvis lang, rele (800) 880-1800.

Si vous-même, ou une personne que vous aidez, avez des questions concernant le MetLife Pediatric Dental Essential Health Benefit Plan (Programme de Prévoyance d'Urgence pour la Santé Dentaire des Enfants), vous êtes en droit d'obtenir gratuitement une assistance et ces informations dans votre langue maternelle. Pour contacter les services de traduction, appelez le (800) 880-1800.

Jeśli Ty, lub osoba, której udzielasz pomocy, ma pytania odnośnie planu MetLife Pediatric Dental Essential Health Benefit Plan (Podstawowy plan świadczeń zdrowotnych MetLife obejmujący pomoc pediatryczną i stomatologiczną), przysługuje wam prawo do otrzymania informacji lub pomocy w ojczystym języku bez żadnych kosztów. Aby skorzystać z pomocy językowej, prosimy dzwonić pod nr (800) 880-1800.

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы по поводу MetLife Pediatric Dental Essential Health Benefit Plan (Базовый педиатрический стоматологический медицинский страховой план Метлайф), у Вас есть право получить помощь и информацию на родном языке бесплатно. Для получения услуг языковой помощи позвоните (800) 880-1800.

Kung ikaw o ang tinutulungan mo, ay mayroong mga tanong tungkol sa MetLife Pediatric Dental Essential Health Benefit Plan (Plan ng Mga Benepisyo para sa Mga Mahalagang Bagay sa Kalusugan ng Ngipin na mula sa MetLife), mayroon kang karapatang humingi ng tulong at impormasyon na nasa wika mo at nang wala kang babayaran. Para ayusin ang mga serbisyo para sa tulong sa wika, tumawag sa (800) 880-1800.

Wenn Sie oder jemand, dem Sie helfen, Fragen zum MetLife Pediatric Dental Essential Health Benefit Plan (Allgemeinen Pädiatrisch-zahnärztlichen Krankenversicherungsplan von MetLife) haben, so stehen Ihnen kostenlos Hilfe und Information in Ihrer Sprache zu. Um Sprachunterstützung anzufordern, rufen Sie bitte (800) 880-1800 an.

MetLife 保険の小児歯科エッセンシャルヘルス・ベネフィット・プランに関してご質問がある場合は、お客様の母国語でのサポートを無料で受けることができます。母国語でのサポートを必要となさる場合は、
(800) 880-1800 までお電話くださいますようお願いいたします。

Se você ou alguém a quem você estiver ajudando tiver alguma dúvida sobre o MetLife Pediatric Dental Essential Health Benefit Plan (Plano Essencial de Benefícios Médicos Dentarios Pediátricos da MetLife), você tem o direito de obter ajuda e informações no seu idioma, sem nenhum custo. Para providenciar serviços de tradução ligue para (800) 880 - 1800.

اگر شما یا کسی که شما به او کمک می کنید، سؤالاتی درباره ی طرح بهره مندی از مزایای بهداشت و سلامت ضروری دندان کودکان MetLife داشته باشید، حق دارید که اطلاعات و کمک مورد نیاز خود را به زبان بومی خود، بدون پرداخت هیچ هزینه ای دریافت کنید. برای ترتیب دادن خدمات مساعدتی زبان، با شماره ی (800) 880-1800 تماس بگیرید.

Se avete domande, o se qualcuno di cui vi occupate ha domande su MetLife Pediatric Dental Essential Health Benefit Plan (Programma Essenziale per la Salute Ortodontica Pediatrica di Metlife), avete il diritto di ottenere assistenza e informazioni nella vostra lingua senza costi aggiuntivi. Per richiedere assistenza in lingua, chiamate (800) 880-1800.