



SafeGuard SCHEDULE OF BENEFITS

INDIVIDUAL PLAN PREMIER CHOICE

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; please review them before your first dental appointment. It is important to discuss all recommended procedures with your provider prior to treatment.

The following co-payments apply only when services are performed by your selected SafeGuard general dentist. If you choose to receive services from a SafeGuard contracted specialty care provider (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 75% of that provider's usual fee for those services. A list of these contracted dentists may be found through SafeGuard's online directory at www.safeguard.net.

In addition, non-listed services are available with your SafeGuard selected general dentist or specialty care dentist at 75% of their usual and customary fees.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention. You may be charged a co-payment if you do not give the dental office at least 24 hours notice.

Benefits provided by SafeGuard Health Plans, Inc.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation – established patient	\$0
D0140	Limited oral evaluation – problem focused	\$5
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D0150	Comprehensive oral evaluation – new or established patient	\$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$0
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	\$0
D0180	Comprehensive periodontal evaluation – new or established patient	\$0
9491	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
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	Panoramic film	\$0
D0350	Oral/facial photographic images	\$0

Code	Service	Co-payment
Tests and Examinations		
D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$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
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
Preventive Services		
D1110	Prophylaxis – adult (limit 2 per 12 months)	\$0
1111	Additional-Adult Prophylaxis (maximum of 2 additional per year)	\$35
D1120	Prophylaxis – child (limit 2 per 12 months)	\$0
1121	Additional-Child Prophylaxis (maximum of 2 additional per year)	\$25
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
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$5
D1510	Space maintainer – fixed – unilateral	\$65
D1515	Space maintainer – fixed – bilateral	\$65
D1520	Space maintainer – removable – unilateral	\$80
D1525	Space maintainer – removable – bilateral	\$80
D1550	Recementation of space maintainer	\$15
D1555	Removal of fixed space maintainer	\$15
Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	\$0
D2150	Amalgam – two surfaces, primary or permanent	\$0
D2160	Amalgam – three surfaces, primary or permanent	\$0
D2161	Amalgam – four or more surfaces, primary or permanent	\$0
D2330	Resin-based composite – one surface, anterior	\$25
D2331	Resin-based composite – two surfaces, anterior	\$35
D2332	Resin-based composite – three surfaces, anterior	\$50
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$70
D2390	Resin-based composite crown, anterior	\$60
D2391	Resin-based composite – one surface, posterior	\$65
D2392	Resin-based composite – two surfaces, posterior	\$75
D2393	Resin-based composite – three surfaces, posterior	\$85
D2394	Resin-based composite – four or more surfaces, posterior	\$85
Crowns		
<ul style="list-style-type: none"> 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 crown/bridge unit in addition to regular co-payments for porcelain on molars. 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. 		
D2510	Inlay – metallic – one surface	\$225
D2520	Inlay – metallic – two surfaces	\$235
D2530	Inlay – metallic – three or more surfaces	\$245
D2543	Onlay – metallic – three surfaces	\$260

Code	Service	Co-payment
D2544	Onlay – metallic – four or more surfaces	\$300
D2610	Inlay – porcelain/ceramic – one surface	\$245
D2620	Inlay – porcelain/ceramic – two surfaces	\$245
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$245
D2740	Crown – porcelain/ceramic substrate	\$245
D2750	Crown – porcelain fused to high noble metal	\$245
D2751	Crown – porcelain fused to predominantly base metal	\$245
D2752	Crown – porcelain fused to noble metal	\$245
D2780	Crown – ¾ cast high noble metal	\$245
D2781	Crown – ¾ cast predominantly base metal	\$245
D2782	Crown – ¾ cast noble metal	\$245
D2790	Crown – full cast high noble metal	\$245
D2791	Crown – full cast predominantly base metal	\$245
D2792	Crown – full cast noble metal	\$245
D2794	Crown – titanium	\$245
D2799	Provisional crown	\$0
D2910	Recement inlay, onlay, or partial coverage restoration	\$15
D2915	Recement cast or prefabricated post and core	\$15
D2920	Recement crown	\$15
D2930	Prefabricated stainless steel crown – primary tooth	\$40
D2931	Prefabricated stainless steel crown – permanent tooth	\$40
D2940	Sedative filling	\$10
D2950	Core buildup, including any pins	\$70
D2951	Pin retention – per tooth, in addition to restoration	\$15
D2952	Post and core in addition to crown, indirectly fabricated	\$85
D2954	Prefabricated post and core in addition to crown	\$75
D2955	Post removal (not in conjunction with endodontic therapy)	\$40
D2960	Labial veneer (resin laminate) – chairside	\$300
D2961	Labial veneer (resin laminate) – laboratory	\$380
D2962	Labial veneer (porcelain laminate) – laboratory	\$380
D2970	Temporary crown (fractured tooth)	\$0
D2980	Crown repair, by report	\$0
Endodontics		
<i>All procedures exclude final restoration.</i>		
D3110	Pulp cap – direct (excluding final restoration)	\$10
D3120	Pulp cap – indirect (excluding final restoration)	\$10
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$30
D3221	Pulpal debridement, primary and permanent teeth	\$55
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	\$40
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$40
D3310	Anterior (excluding final restoration)	\$110
D3320	Bicuspid (excluding final restoration)	\$185
D3330	Molar (excluding final restoration)	\$265
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$110
D3346	Retreatment of previous root canal therapy – anterior	\$180
D3347	Retreatment of previous root canal therapy – bicuspid	\$280
D3348	Retreatment of previous root canal therapy – molar	\$325
D3351	Apexification/recalcification – initial visit (apical closure/calccific repair of perforations, root resorption, etc.)	\$90

Code	Service	Co-payment
D3352	Apexification/recalcification – interim medication replacement (apical closure/calccific repair of perforations, root resorption, etc.)	\$90
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calccific repair of perforations, root resorption, etc.)	\$90
D3410	Apicoectomy/periradicular surgery – anterior	\$100
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$100
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$100
D3426	Apicoectomy/periradicular surgery (each additional root)	\$60
D3430	Retrograde filling – per root	\$60
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	\$110
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	\$83
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	\$150
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	\$113
D4249	Clinical crown lengthening – hard tissue	\$150
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	\$245
D4271	Free soft tissue graft procedure (including donor site surgery)	\$245
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)	\$100
D4320	Provisional splinting – intracoronal	\$95
D4321	Provisional splinting – extracoronal	\$95
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$50
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$38
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$50
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$65
D4910	Periodontal maintenance (2 in a 12 month period)	\$40
4911	Additional Periodontal Maintenance Procedures (beyond 2 per 12 months)	\$55
D4999	Periodontal Charting for planning treatment of periodontal disease	\$0
D4999	Periodontal Hygiene Instruction	\$0
Removable Prosthodontics		
<i>Includes up to 3 adjustments within 6 months of delivery.</i>		
D5110	Complete denture – maxillary	\$325
D5120	Complete denture – mandibular	\$325
D5130	Immediate denture – maxillary	\$350
D5140	Immediate denture – mandibular	\$350
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$400

Code	Service	Co-payment
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$400
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$425
D5410	Adjust complete denture – maxillary	\$10
D5411	Adjust complete denture – mandibular	\$10
D5421	Adjust partial denture – maxillary	\$10
D5422	Adjust partial denture – mandibular	\$10
D5510	Repair broken complete denture base	\$35
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$35
D5610	Repair resin denture base	\$35
D5620	Repair cast framework	\$35
D5630	Repair or replace broken clasp	\$35
D5640	Replace broken teeth – per tooth	\$35
D5650	Add tooth to existing partial denture	\$35
D5660	Add clasp to existing partial denture	\$35
D5710	Rebase complete maxillary denture	\$75
D5711	Rebase complete mandibular denture	\$75
D5720	Rebase maxillary partial denture	\$75
D5721	Rebase mandibular partial denture	\$75
D5730	Reline complete maxillary denture (chairside)	\$65
D5731	Reline complete mandibular denture (chairside)	\$65
D5740	Reline maxillary partial denture (chairside)	\$65
D5741	Reline mandibular partial denture (chairside)	\$65
D5750	Reline complete maxillary denture (laboratory)	\$85
D5751	Reline complete mandibular denture (laboratory)	\$85
D5760	Reline maxillary partial denture (laboratory)	\$85
D5761	Reline mandibular partial denture (laboratory)	\$85
D5820	Interim partial denture (maxillary)	\$175
D5821	Interim partial denture (mandibular)	\$175
D5850	Tissue conditioning, maxillary	\$20
D5851	Tissue conditioning, mandibular	\$20

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 crown/bridge unit in addition to regular co-payments for porcelain on molars.

• 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.

D6210	Pontic – cast high noble metal	\$245
D6211	Pontic – cast predominantly base metal	\$245
D6212	Pontic – cast noble metal	\$245
D6214	Pontic – titanium	\$245
D6240	Pontic – porcelain fused to high noble metal	\$245
D6241	Pontic – porcelain fused to predominantly base metal	\$245
D6242	Pontic – porcelain fused to noble metal	\$245
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$245
D6721	Crown – resin with predominantly base metal	\$245
D6750	Crown – porcelain fused to high noble metal	\$245
D6751	Crown – porcelain fused to predominantly base metal	\$245

Code	Service	Co-payment
D6752	Crown – porcelain fused to noble metal	\$245
D6780	Crown – ¾ cast high noble metal	\$245
D6781	Crown – ¾ cast predominantly base metal	\$245
D6782	Crown – ¾ cast noble metal	\$245
D6790	Crown – full cast high noble metal	\$245
D6791	Crown – full cast predominantly base metal	\$245
D6792	Crown – full cast noble metal	\$245
D6794	Crown – titanium	\$245
D6930	Recement fixed partial denture	\$15
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$85
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$75
D6973	Core build up for retainer, including any pins	\$70
D6980	Fixed partial denture repair, by report	\$45

Oral Surgery

• Includes routine post operative visits/treatment.

• The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

D7111	Extraction, coronal remnants – deciduous tooth	\$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$5
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	\$65
D7240	Removal of impacted tooth – completely bony	\$80
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50
D7280	Surgical access of an unerupted tooth	\$200
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$150
D7286	Biopsy of oral tissue – soft	\$150
D7287	Exfoliative cytological sample collection	\$50
D7288	Brush biopsy – transepithelial sample collection	\$50
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$40
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$15
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$60
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$25
D7510	Incision and drainage of abscess – intraoral soft tissue	\$35
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$50
D7963	Frenuloplasty	\$50
D7971	Excision of pericoronal gingiva	\$40

Code	Service	Co-payment
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Orthodontics

Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.

D8010	Limited orthodontic treatment of the primary dentition	75% of U&C
D8020	Limited orthodontic treatment of the transitional dentition	75% of U&C
D8030	Limited orthodontic treatment of the adolescent dentition	75% of U&C
D8040	Limited orthodontic treatment of the adult dentition	75% of U&C
D8050	Interceptive orthodontic treatment of the primary dentition	75% of U&C
D8060	Interceptive orthodontic treatment of the transitional dentition	75% of U&C
D8070	Comprehensive orthodontic treatment of the transitional dentition	75% of U&C
D8080	Comprehensive orthodontic treatment of the adolescent dentition	75% of U&C
D8090	Comprehensive orthodontic treatment of the adult dentition	75% of U&C
D8210	Removable appliance therapy	75% of U&C
D8220	Fixed appliance therapy	75% of U&C
D8660	Pre-orthodontic treatment visit	75% of U&C
D8670	Periodic orthodontic treatment visit (as part of contract)	75% of U&C
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	75% of U&C
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	75% of U&C
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	75% of U&C
D8999	Ortho visits beyond 24 months of active treatment or retention	75% of U&C

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$10
D9120	Fixed partial denture sectioning	\$0
D9215	Local anesthesia	\$0
D9220	Deep sedation/general anesthesia – first 30 minutes	\$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	\$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	\$150
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	\$45
D9248	Non-intravenous conscious sedation	\$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$5
D9440	Office visit – after regularly scheduled hours	\$30
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9630	Other drugs and/or medicaments, by report	\$15
D9940	Occlusal guard, by report	\$85
D9951	Occlusal adjustment – limited	\$30
D9952	Occlusal adjustment – complete	\$100
D9972	External bleaching – per arch	\$125
D9999	Broken appointment (less than 24-hour notice)	Not to exceed \$25

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

Dental Limitations

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to 2 per 12 months. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional \$125 co-payment per unit in addition to the specified co-payment for each crown/bridge unit.
4. There is a \$75 co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

Prostodontics

1. Relines 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 functioning tooth. 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 SafeGuard selected general dentist.
3. Delivery of removable prostodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

Dental General Exclusions

1. Services performed by any dentist not contracted with SafeGuard, without prior approval by SafeGuard (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
3. 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.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary 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 specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
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 in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

Orthodontic Exclusions & Limitations

Your co-payments will be 75% of your selected SafeGuard general or specialty care dentist's usual and customary fees. If your general dentist does not provide orthodontic care, you may receive care from a SafeGuard contracted dentist whose practice is limited to orthodontic care. A listing of contracted dentists whose practice is limited to orthodontic care can be found online at www.safeguard.net, or you may call Customer Service.

If you terminate coverage from the SafeGuard Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a SafeGuard selected general dentist or SafeGuard contracted orthodontist in order for the co-payments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-visit charge of 75% of your SafeGuard selected general dentist's or Safeguard contracted orthodontist's usual and customary fees.
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 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.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.



Underwritten by SafeHealth Life Insurance Company

Individual Vision Rider Indemnity Plan

SAFEHEALTH LIFE INSURANCE COMPANY
Post Office Box 30930
Laguna Hills, CA 92654-0930

INDIVIDUAL ACCIDENT AND HEALTH
Vision Indemnity/PPO Master Policy Rider

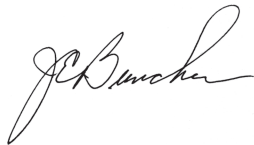
The Policyholder is:
Policy Number:

SafeHealth Life Insurance Company (“SafeHealth”) insures, subject to the provisions, limitations and other terms contained herein, as part of the Dental agreement that this rider is attached to, it is agreed that each Covered Person shall be entitled to receive vision benefits in accordance with the Summary of Benefits set forth below and subject to the Exclusions and Limitations set forth below. Vision benefits are available under this Plan only while the Covered Person is enrolled in SafeGuard. Should the Covered Person terminate from SafeGuard for any reason, the benefits available through this rider shall end in accordance with the terms of the SafeGuard Master Policy.

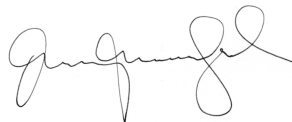
CONSIDERATION. This Policy Rider is issued in consideration of the payment of premiums and the other terms set forth in the Master Policy to which it is attached.

ADDITIONAL PAGES. The provisions, limitations and other terms set forth in this Policy Rider are a part of this contract as fully as if appearing over the signature hereto.

IN WITNESS WHEREOF – SafeHealth has caused this Policy Rider to be executed effective at 12:01 A.M., Standard Time on _____, at the address of the Policyholder for an initial term of one year. This Policy may be renewed thereafter as herein provided.



JAMES E. BUNCHER
 Chief Executive Officer



RONALD I. BRENDZEL
 Senior Vice President and Secretary

This plan contains a deductible provision.

NOTICE OF TEN (10) DAY RIGHT TO EXAMINE POLICY

You may return this Policy for cancellation within ten (10) days of its delivery to you and your premium will be fully refunded, if after examination of the Policy, you are not satisfied with it for any reason.

If you return the Policy to the Company it shall be void from the beginning and you and the Company will be in the same position as if no Policy had been issued.

SECTION I - Vision Rider Benefit Information

As part of the Dental agreement that this rider is attached to, it is agreed that each Covered Person shall be entitled to receive vision benefits in accordance with the Summary of Benefits set forth below and subject to the Exclusions and Limitations set forth below. Vision benefits are available under this Plan only while the Covered Person is enrolled in SafeGuard. Should the Covered Person terminate from SafeGuard for any reason, the benefits available through this rider shall end in accordance with the terms of the SafeGuard Master Policy or agreement, as applicable.

SECTION II – Summary of Vision Benefits

This vision plan includes in- and out-of-network benefits as listed below; if a Covered Person visits an in-network provider, the Covered Person will receive the maximum benefit. If a Covered Person chooses to see an out-of-network provider, the Covered Person will be reimbursed for services as indicated in the “Out-of-network Coverage” section of this schedule.

Frequency (months)	Exam
	12

	In-Network Coverage (Using a Network Provider)	Out-of-Network Coverage (Using a Non-Network Provider)
Exam	Co-payment \$20	Your Reimbursement \$35 Covered Persons are responsible for the provider’s usual charge; reimbursement for the amount listed will be paid upon receipt of the claim.

Please note:

If a Covered Person wishes to purchase non-covered frames, lenses or contact lenses from a contracted vision care provider, the Covered Person will be responsible for as little as 80% of that provider’s usual charge for frames and lenses and as little as 80% for contact lenses (excluding disposable and planned replacement contact lenses).

SECTION III – Vision Exclusions and Limitations

Except as otherwise provided in the Summary of Benefits, the following are excluded from coverage:

1. Charges for procedures, services or materials that are not included as covered charges; however, contracted vision providers have agreed to offer these services for as little as 80% of their usual fees.
2. Any portion of a charge in excess of the allowance or reimbursement indicated in the Summary of Benefits.
3. Expenses for any non-covered lens materials, including but not limited to the following: coated, dyed, glass lens or laminated lenses, progressive, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromic/photosensitive; however, contracted vision providers have agreed to offer these services for as little as 80% of their usual fees.
4. Orthoptics, vision training and any associated supplemental testing.
5. Medical or surgical treatment of the eye. Coverage limited to laser refractive surgery benefit included as covered charges.
6. Prescription or non-prescription medications.
7. Any eye examination or any corrective eyewear required as a condition of employment.
8. Services or materials that are experimental, cosmetic or not medically necessary.
9. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
10. Services and materials furnished in conjunction with excluded services and materials.
11. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
12. Services and materials that a covered person received during a service interval under any other plan offered by the Company or one of the Company's affiliates.
13. Charges incurred before a covered person's effective date of coverage under the Policy or after such coverage terminates.
14. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
15. Services and materials obtained while outside the United States, except for emergency vision care.
16. Services or materials resulting from or in the course of a covered person's regular occupation for pay or profit for which the covered person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
17. Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States;
18. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

SECTION IV – Related Provisions

The following additional provisions are added to your Dental Evidence of Coverage or agreement, as applicable, by the attachment of this rider:

Choice of Vision Provider/ Receiving Care

If a Covered Person wants to see a contracted vision provider (in-network provider), please refer to the **Directory of Participating Vision Care Providers**. By using an in-network provider, a Covered Person's specific benefits will be those noted as In-Network Coverage on the Summary of Benefits. A Covered Person may obtain a Vision Care Provider Directory by calling our Customer Service Department at (800) 880-1800 or by visiting **www.safeguard.net**.

If a Covered Person wishes to see a licensed provider not listed in our directory for covered vision services, a Covered Person may do so. By receiving services from an out-of-network provider, a Covered Person's specific benefits will be those noted as Out-of-Network Coverage on the Summary of Benefits and may be less than would be received from an in-network vision provider.

New Patient and Routine Services

Making a Vision Appointment

Once a Covered Person's coverage begins, the Covered Person may contact the vision provider of choice to schedule an appointment. SafeHealth Participating Vision Care Provider Offices are open in accordance with their individual practice needs. When scheduling an appointment, the Covered Person should identify himself/herself as a SafeHealth member.

Referrals for Vision Specialty Care

A Covered Person may choose to receive benefits from any SafeHealth vision provider, including contracted ophthalmologists. A list of SafeHealth participating vision care providers may be found online at www.safeguard.net or obtained by calling Customer Service (800-880-1800) for assistance. Treatment by a non-participating vision provider is covered at the out of network reimbursement level shown on the *Vision Summary of Benefits*.

Financial Responsibility

Deductible

Deductible refers to the fixed dollar amount that a Covered Person may be responsible for each calendar year or contract year prior to any benefits being received. The Deductible, if any, is set forth on the Summary of Benefits.

Vision Co-payments

The Vision benefits available under this plan are set forth in the Summary of Benefits. The Benefit may be a percentage amount or a Maximum Benefit Allowance. A Covered Person will be responsible for all fees and charges in excess of the percentage amount and/or Maximum Benefit Allowance listed in the Summary of Benefits (as well as the deductible, if any). See "Covered Vision Services and Materials" for more information.

Certain covered charges may be payable under the Policy only if the service or material is furnished by a contracted Vision Care Provider. If this is the case, it will be indicated in the Summary of Benefits. It is the Covered Person's responsibility to determine if a Vision Care Provider is a contracted (in-network) provider at the time that the service or material is provided.

Identification Card

The Covered Person should present the identification card to a Vision Provider before receiving services.

Covered Vision Services and Materials

Subject to the Service Intervals and Maximum Benefit Allowances indicated in the Summary of Benefits, the following will be covered charges under the Plan:

1. One complete visual examination. Dilation is included as a covered service when provided by the contracted Vision Care Provider.

Corrective lenses, frames, and Medically necessary or non-medically necessary contact lenses are not covered under the Plan. If a Covered Person chooses to purchase these materials from a participating vision provider, fees will be as little as eighty percent (80%) of the contracted vision provider's usual fees and paid by the member. If a Covered Person chooses to purchase these materials from a non-participating vision provider, fees will be the usual fees of that provider and paid by the member.

Please refer to the Summary of Benefits for the Exclusions and Limitations applicable to the vision plan.

Exclusions and Limitations

Please refer to the Summary of Benefits for the Exclusions and Limitations applicable to the vision plan.

Payment of Vision Claims

All out-of-network vision benefits will be paid directly to the Covered Person unless otherwise directed. SafeHealth does not require that vision services be rendered by a particular provider.

Definitions

These definitions are added to the Definitions of the Master Policy or agreement and apply when the following terms are used, unless otherwise defined where they are used.

Close Relative

A Covered Person's spouse, children, parents, brothers, and sisters; and b) any other person who is part of a Covered Person's household.

Contracted (Preferred or In-Network) Vision Provider

A Vision Care Provider who has a written contract with SafeHealth to furnish services and supplies and accepts reimbursements at the negotiated rate.

Covered Person/ Member

An individual enrolled in the SafeHealth vision plan, including the Policyholder or his or her Dependent(s) covered under the Plan.

Covered Vision Services

Charges for Covered Services and Materials. With respect to Contracted Vision Providers, Covered Vision Charges means the Negotiated Rate. With respect to Non-Participating Vision Providers, charges in excess of SafeHealth's Maximum Benefit Allowance will not be considered Covered Charges under the plan.

Covered Vision Services and Materials

The services and materials indicated in this Plan that are payable or eligible for reimbursement, subject to any benefit limitations and maximums, under the Plan.

Deductible

The amount of covered charges that must be paid by a Covered Person in each Calendar Year before payment is made by SafeHealth.

Maximum Benefit Allowance

The maximum amount SafeHealth will allow for covered services and materials provided by a Vision Care Provider.

Preferred (contracted or in-network) Provider

A Vision Provider who has a written contract with SafeHealth to furnish services and supplies and accepts reimbursement at the negotiated rate.

Vision Care Provider or Vision Provider

An eye care professional who is an optometrist, ophthalmologist, or registered dispensing optician, who:

1. Is licensed as such by the proper authorities of the state in which he or she practices;
2. Is acting within the scope of such license; and
3. Is not a relative or member of the household of the Covered Person.

Vision Service Interval

A period of consecutive months, as shown in the Summary of Benefits, in which a Covered Person may receive covered services and materials. This period starts on the Covered Person's effective date of coverage and then a subsequent service interval starts after vision services or materials are received. Once Covered Vision Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.