SAFEGUARD DENTAL

How To Enroll

1). Complete and sign the Enrollment Form and Membership Agreement Form. Choose a dentist from the provider directory or call your agent or (951) 215-0420 for help.

2). Request your effective date. Completed forms returned by the *25th* of the month will be go into effect on the 1st of the following month.

3). You will be billed monthly unless you complete the credit card authorization form.

4). Send (1) Month's premium PLUS a one time $15.00 enrollment fee per application and $2.00 administration fee. **Make check payable to CCSB Administrators.**
Return your completed application to your agent.

Monthly Rates

Individual	$47.00
Couple	$63.00
Family	$80.00

***Plus a onetime $15 enrollment fee**
Also add $2.00 for monthly administration fee

MEMBERSHIP AGREEMENT

I hereby apply for membership into the
ASSOCIATION of CHAMBER MEMBERS

A. I am also applying for the SAFEGUARD DENTAL PLAN. I UNDERSTAND AND AGREE THAT: My application is subject to approval by ACM.

B. CCSB Insurance Administrators (CCSB) is the third party administrator providing the billing services.

C. Neither ACM, CCSB nor other marketing affiliates administer any services or claims for the plan and assumes no liability other than for receiving and distributing premiums and dues.

D. Not all benefits, exclusions, limitations and service settlement methods are printed on this flier. I understand that a full copy of the Safeguard Evidence of Coverage and Plan Benefit Disclosure for SageGuard Plan SG230 is available to me by my request.

E. An unsettled controversy between any parties to this Agreement shall be settled by binding arbitration in accordance with the provisions of the California Arbitration Act of the California Code of Civil Procedures. The cost of such arbitration shall be borne
by the losing party or in such proportions as the arbitrator shall decide.

F. All necessary dental services will be charged as described in the Safeguard Evidence of Coverage and Benefits Summary for plan SG230. I realize that I and all my eligible dependents are subject to all the terms and conditions of this plan.

G. If I purchase this plan through my employer, I authorize my employer to make appropriate payroll deduction and forward this amount to the administrator as billed.

H. If the plan fails to pay a *non-participating* dental provider, the plan member may be liable to such provider for the cost of services received by that member.

I. Association dues must be received by the 20th of the month as billed when due or coverage will cease.

X_____ _____

Applicant Signature **Date Signed**

AGENT NAME_____

Credit Card Authorization

Member or company name_____

SELECT YOUR METHOD OF PAYMENT (check one)

_VISA _ MASTERCARD

Acct # |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Exp. ____/____/____

Security Code _____

Name on card_____

Billing address

_____

(street, city, state, zip)

Your credit card will be charged Monthly

I HEREBY AUTHORIZE CCSB to initiate debits from the credit card/ financial institution account indicated above and authorize my credit card company/ financial institution to honor those debits. I further agree that CCSB will be fully protected in honoring such debt.
To terminate or cancel the member agreement, please call (951) 215-0420 or send a written cancellation notice to CCSB, 231 East Alessandro Blvd., Ste A359, Riverside, CA 92508. This agreement can be cancelled for non-payment.

SIGN HERE_____
(signature required)

Note that the deduction on your credit card statement will say by CCSB Insurance.

CCSB
231 East Alessandro, Blvd. Ste A359
Riverside, CA 92508
T: (951) 215-0420 F: (951) 780-2958

MetLife

SafeGuard Dental HMO Enrollment Form (California)

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

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

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire
Assoc. for Communication and Marketing	**5753082**		
Employee's Occupation	Division	Class	Dept. Code

Subscriber's Information

Last Name	First Name	MI	Subscriber SS# - -

Home Address	Apt. #

City	State	Zip Code

Male/Female	Date of Birth	Home Telephone ( ) -	Work Telephone ( ) -	Ext.

Must be completed to enroll in plan:	**Facility Number - 1st Choice**	**Facility Number – 2nd Choice**

Facility numbers are found next to each General Dentist's name in the SafeGuard Directory of Participating Dentists.

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	**Facility Number 1st Choice**	**Facility Number 2nd Choice**

Must be completed to enroll in plan:

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

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

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

Waiver of Coverage

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

☐ Do not choose to elect this coverage.

Your Name (Please Print)	Your Signature	Date

"DHMO" is used to refer to "Specialized Health Care Service Plans" in California.

IMPORTANT

PLEASE KEEP YOUR BENEFIT OUTLINE IN A PLACE WHERE IT CAN BE EASILY LOCATED. WE ALSO STRONGLY SUGGEST THAT YOU TAKE THIS OUTLINE WITH YOU WHEN VISITING THE DENTIST TO HELP ENSURE THAT YOU ARE PAYING THE CORRECT COPAYMENTS.

Listen to Your Dentist – Ask Questions

It is very important that you fully understand the treatment plan presented by your dentist. There may be several options presented to you, so you will want to ask questions such as; "Which treatment is covered under my plan." "Which treatment is considered an upgrade or optional?" Ask your dentist to explain the options and the differences between them so you can make an informed decision about Your treatment. And always make sure you understand the co-payments associated with the treatment. **If you have questions about the co-payments being quoted by your dentist, please call your dental plan's Member Services Department for assistance:**

Liberty Dental Plan 888-703-6999

Safeguard/Metlife 800-880-1800

For questions on your monthly invoice call:
CCSB Insurance Administrators 951-215-0420

SafeGuard® SCHEDULE OF BENEFITS

Direct Referral Dental Plan* SG230

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.

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

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

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	$20
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
	Office visit - per visit (including all fees for sterilization and/ or infection control)	$5
Radiographs/Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series (including bitewings)	$10
D0220	Intraoral – periapical first film	$0
D0230	Intraoral – periapical each additional film	$0
D0240	Intraoral – occlusal film	$0
D0250	Extraoral – first film	$0
D0260	Extraoral – each additional film	$0
D0270	Bitewing – single film	$0
D0272	Bitewings – two films	$0
D0273	Bitewings – three films	$0
D0274	Bitewings – four films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
Tests and Examinations		
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0

Code	Service	Co-payment
Preventive Services		
	Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.	
D1110	Prophylaxis – adult*	$5
D1120	Prophylaxis – child*	$5
D1203	Topical application of fluoride (prophylaxis not included) – child*	$0
D1204	Topical application of fluoride (prophylaxis not included) – adult*	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients*	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$10
D1510	Space maintainer – fixed – unilateral	$60
D1515	Space maintainer – fixed – bilateral	$60
D1520	Space maintainer – removable – unilateral	$60
D1525	Space maintainer – removable – bilateral	$60
D1550	Recementation of space maintainer	$0
D1555	Removal of fixed space maintainer	$0
Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	$10
D2150	Amalgam – two surfaces, primary or permanent	$15
D2160	Amalgam – three surfaces, primary or permanent	$20
D2161	Amalgam – four or more surfaces, primary or permanent	$20
D2330	Resin-based composite – one surface, anterior	$15
D2331	Resin-based composite – two surfaces, anterior	$20
D2332	Resin-based composite – three surfaces, anterior	$22
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$32
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$65
D2392	Resin-based composite – two surfaces, posterior	$75
D2393	Resin-based composite – three surfaces, posterior	$80
D2394	Resin-based composite – four or more surfaces, posterior	$80
Crowns		
	• *Replacement limit 1 every 5 years.*	
	• *An additional charge will be applied for any procedure using noble or high noble metal.*	
	• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*	
	• *$75 fee per crown unit above co-pay for porcelain on molars.*	
D2510	Inlay – metallic – one surface	$115
D2520	Inlay – metallic – two surfaces	$135
D2530	Inlay – metallic – three or more surfaces	$150
D2543	Onlay – metallic – three surfaces	$230
D2544	Onlay – metallic – four or more surfaces	$230
D2740	Crown – porcelain/ceramic substrate	$250
D2750	Crown – porcelain fused to high noble metal	$230
D2751	Crown – porcelain fused to predominantly base metal	$230
D2752	Crown – porcelain fused to noble metal	$230
D2780	Crown – ¾ cast high noble metal	$230
D2781	Crown – ¾ cast predominantly base metal	$230
D2782	Crown – ¾ cast noble metal	$230
D2790	Crown – full cast high noble metal	$230
D2791	Crown – full cast predominantly base metal	$230
D2792	Crown – full cast noble metal	$230

Code	Service	Co-payment
D2794	Crown – titanium	$230
D2910	Recement inlay, onlay, or partial coverage restoration	$8
D2915	Recement cast or prefabricated post and core	$8
D2920	Recement crown	$8
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	$40
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	$85
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2970	Temporary crown (fractured tooth)	$0

Endodontics

All procedures exclude final restoration.

D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$3
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$25
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$30
D3310	Anterior (excluding final restoration)	$150
D3320	Bicuspid (excluding final restoration)	$180
D3330	Molar (excluding final restoration)	$300
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$150
D3346	Retreatment of previous root canal therapy – anterior	$160
D3347	Retreatment of previous root canal therapy – bicuspid	$190
D3348	Retreatment of previous root canal therapy – molar	$310
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$80
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$80
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$80
D3410	Apicoectomy/periradicular surgery – anterior	$180
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$180
D3425	Apicoectomy/periradicular surgery – molar (first root)	$180
D3426	Apicoectomy/periradicular surgery (each additional root)	$80
D3430	Retrograde filling – per root	$60
D3450	Root amputation – per root	$60
D3920	Hemisection (including any root removal), not including root canal therapy	$70

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	$225
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	$169

Code	Service	Co-payment
D4249	Clinical crown lengthening – hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	$225
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	$169
D4270	Pedicle soft tissue graft procedure	$250
D4271	Free soft tissue graft procedure (including donor site surgery)	$250
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$65
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$49
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$30
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance (2 in a 12 month period)	$35

Removable Prosthodontics

- *Relines are limited to 1 every 24 months.*
- *Includes up to 3 adjustments within 6 months of delivery.*

D5110	Complete denture – maxillary	$300
D5120	Complete denture – mandibular	$300
D5130	Immediate denture – maxillary	$345
D5140	Immediate denture – mandibular	$345
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$235
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$235
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$345
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$345
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	$30
D5520	Replace missing or broken teeth – complete denture (each tooth)	$30
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$40
D5630	Repair or replace broken clasp	$40
D5640	Replace broken teeth – per tooth	$30
D5650	Add tooth to existing partial denture	$40
D5660	Add clasp to existing partial denture	$40
D5710	Rebase complete maxillary denture	$100
D5711	Rebase complete mandibular denture	$100
D5720	Rebase maxillary partial denture	$100
D5721	Rebase mandibular partial denture	$100
D5730	Reline complete maxillary denture (chairside)	$50
D5731	Reline complete mandibular denture (chairside)	$50
D5740	Reline maxillary partial denture (chairside)	$50
D5741	Reline mandibular partial denture (chairside)	$50
D5750	Reline complete maxillary denture (laboratory)	$85

Code	Service	Co-payment
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)	$75
D5821	Interim partial denture (mandibular)	$75
D5850	Tissue conditioning, maxillary	$20
D5851	Tissue conditioning, mandibular	$20

Crowns/Fixed Bridges - Per Unit

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

D6210	Pontic – cast high noble metal	$230
D6211	Pontic – cast predominantly base metal	$230
D6212	Pontic – cast noble metal	$230
D6214	Pontic – titanium	$230
D6240	Pontic – porcelain fused to high noble metal	$230
D6241	Pontic – porcelain fused to predominantly base metal	$230
D6242	Pontic – porcelain fused to noble metal	$230
D6750	Crown – porcelain fused to high noble metal	$230
D6751	Crown – porcelain fused to predominantly base metal	$230
D6752	Crown – porcelain fused to noble metal	$230
D6780	Crown – ¾ cast high noble metal	$230
D6781	Crown – ¾ cast predominantly base metal	$230
D6782	Crown – ¾ cast noble metal	$230
D6790	Crown – full cast high noble metal	$230
D6791	Crown – full cast predominantly base metal	$230
D6792	Crown – full cast noble metal	$230
D6794	Crown – titanium	$230
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	$85
D6973	Core build up for retainer, including any pins	$40

Oral Surgery

- *Includes routine post operative visits/treatment.*
- *Surgical removal of impacted teeth not covered unless pathology (disease) exists.*
- *Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.*

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partially bony	$70
D7240	Removal of impacted tooth – completely bony	$90
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical access of an unerupted tooth	$120
D7285	Biopsy of oral tissue – hard (bone, tooth)	$50

Code	Service	Co-payment
D7286	Biopsy of oral tissue – soft	$35
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$30
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$10
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$20
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$20
D7963	Frenuloplasty	$20
D7971	Excision of pericoronal gingiva	$40

Orthodontics

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

D8020	Limited orthodontic treatment of the transitional dentition	$1,095
D8030	Limited orthodontic treatment of the adolescent dentition	$1,095
D8040	Limited orthodontic treatment of the adult dentition	$1,095
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,095
D8660	Pre-orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain – minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9215	Local anesthesia	$0
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit – after regularly scheduled hours	$25
D9630	Other drugs and/or medicaments, by report	$15
D9951	Occlusal adjustment – limited	$15
D9952	Occlusal adjustment – complete	$30
D9999	Broken appointment (less than 24 hour notice)	$20

SG230-SOB Customer Service (800) 880-1800 10/08

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat the nerve or the pulp of the tooth due to injury or infection.

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Scaling and polishing of teeth by removal of the plaque above the gum line.

Prosthodontics: The restoration of natural and/or the replacement of missing teeth with artificial substitutes.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings

Exclusions and Limitations

Exclusions

1. Services performed by a general dentist or specialty care dentist, not contracted with SafeGuard, without prior approval by SafeGuard (except for out of area emergency services).
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
4. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist.
5. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
6. Orthognathic surgery.
7. General anesthesia or intravenous sedation.
8. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
9. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
10. Treatment of malignancies, cysts, or neoplasms.
11. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
12. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
13. Precision attachments.
14. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Limitations

1. Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.
2. An additional charge will be applied for any procedure using noble or high noble metal.
3. Relines are limited to one every twenty four (24) months.
4. Full-mouth X-rays: Once every three (3) years, unless medically necessary.
5. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.

Exclusions and Limitations

6. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.
7. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
8. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
9. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.
10. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
11. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
12. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
13. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.
14. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist in order for the co-payments listed in the Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.
3. The following are not included as orthodontic benefits:
   - A. Repair or replacement of lost or broken appliances;
   - B. Retreatment of orthodontic cases;
   - C. Treatment in progress at inception of eligibility;
   - D. Interceptive orthodontics;
   - E. Changes in treatment necessitated by an accident;
   - F. Treatment involving:
     1.) Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
     2.) Hormonal imbalances or other factors affecting growth or developmental abnormalities;
     3.) Treatment related to temporomandibular joint disorders;
     4.) Lingually placed direct bonded appliances and arch wires (“invisible braces”); and
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.