MetLife

SCHEDULE OF BENEFITS

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

Self-Referral Dental Plan TX300D

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.

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 dentist whose practice is limited to specialty care (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 70% of that dentist's usual fee for those services. A list of these contracted dentists may be found through SafeGuard's online directory at www.metlife.com/mybenefits.

Code	Service	Co-payment
	Diagnostic Treatment	
	Diagnostic procedures which are references below with frequency limitations are limited unless medically necessary.	
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0171	Re-evaluation – post-operative office visit	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$18
	• Office visit - per visit (including all fees for sterilization and/or infection control)	$3
	Radiographs/Diagnostic Imaging (X-rays)	
D0210	Intraoral – complete series of radiographic images	$0
D0220	Intraoral – periapical first radiographic image	$0
D0230	Intraoral – periapical each additional radiographic image	$0
D0240	Intraoral – occlusal radiographic image	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing – single radiographic image	$0
D0272	Bitewings – two radiographic images	$0
D0273	Bitewings – three radiographic images	$0
D0274	Bitewings – four radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	$0
D0460	Pulp vitality tests	$0

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D0470	Diagnostic casts	$0
	Preventive Services	
	• *Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.*	
D1110	Prophylaxis – adult*	$18
D1120	Prophylaxis – child*	$9
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$10
D1510	Space maintainer – fixed, unilateral – per quadrant Excludes a distal shoe space maintainer.	$50
D1516	Space maintainer – fixed – bilateral, maxillary	$50
D1517	Space maintainer – fixed – bilateral, mandibular	$50
D1520	Space maintainer – removable, unilateral – per quadrant	$50
D1526	Space maintainer – removable – bilateral, maxillary	$50
D1527	Space maintainer – removable – bilateral, mandibular	$50
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$0
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$0
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$0
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0
D1557	Removal of fixed bilateral space maintainer – maxillary	$0
D1558	Removal of fixed bilateral space maintainer – mandibular	$0
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$11
D2150	Amalgam – two surfaces, primary or permanent	$13
D2160	Amalgam – three surfaces, primary or permanent	$15
D2161	Amalgam – four or more surfaces, primary or permanent	$15
D2330	Resin-based composite – one surface, anterior	$15
D2331	Resin-based composite – two surfaces, anterior	$18
D2332	Resin-based composite – three surfaces, anterior	$23
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$23
D2391	Resin-based composite – one surface, posterior	$48
D2392	Resin-based composite – two surfaces, posterior	$68
D2393	Resin-based composite – three surfaces, posterior	$115
D2394	Resin-based composite – four or more surfaces, posterior	$115
	Crowns	
	• *Replacement limit 1 every 5 years.*	
	• *The use of noble or high noble for any procedure will include additional lab fees.*	
	• *Cases involving 5 or more crowns in the same treatment plan require an additional lab fee.*	
	• *$75 fee per crown unit above co-pay for porcelain on molars.*	
D2410	Gold foil – one surface	$60
D2420	Gold foil – two surfaces	$140

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D2430	Gold foil-three surfaces	$180
D2510	Inlay – metallic – one surface	$170
D2520	Inlay – metallic – two surfaces	$170
D2530	Inlay – metallic – three or more surfaces	$170
D2610	Inlay – porcelain/ceramic – one surface	$220
D2710	Crown – resin - based composite (indirect)	$155
D2712	Crown – ¾ resin - based composite (indirect)	$175
D2720	Crown - resin with high noble metal	$155
D2721	Crown - resin with predominantly base metal	$155
D2722	Crown - resin with noble metal	$155
D2740	Crown - porcelain/ceramic	$195
D2750	Crown – porcelain fused to high noble metal	$195
D2751	Crown – porcelain fused to predominantly base metal	$195
D2752	Crown – porcelain fused to noble metal	$195
D2753	Crown - porcelain fused to titanium and titanium alloys	$195
D2780	Crown – ¾ cast high noble metal	$185
D2781	Crown – ¾ cast predominantly base metal	$185
D2782	Crown – ¾ cast noble metal	$185
D2790	Crown – full cast high noble metal	$185
D2791	Crown – full cast predominantly base metal	$185
D2792	Crown – full cast noble metal	$185
D2794	Crown - titanium and titanium alloys	$195
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$12
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$12
D2920	Re-cement or re-bond crown	$12
D2930	Prefabricated stainless steel crown – primary tooth	$50
D2940	Protective restoration	$5
D2950	Core buildup, including any pins when required	$45
D2951	Pin retention – per tooth, in addition to restoration	$45
D2952	Post and core in addition to crown, indirectly fabricated	$50
D2954	Prefabricated post and core in addition to crown	$47
D2960	Labial veneer (resin laminate) - chairside	$90
D2962	Labial veneer (porcelain laminate) – laboratory	$240
	Endodontics	
	• *All procedures exclude final restoration.*	
D3110	Pulp cap – direct (excluding final restoration)	$5
D3120	Pulp cap – indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$20
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$95
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$118
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$175
D3331	Treatment of root canal obstruction; non-surgical access	$190
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$50
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of	$7

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
	perforations, root resorption, etc.)	
D3410	Apicoectomy – anterior	$100
D3421	Apicoectomy - premolar (first root)	$100
D3425	Apicoectomy – molar (first root)	$100
D3426	Apicoectomy (each additional root)	$100
D3430	Retrograde filling – per root	$30
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$100
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$75
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$190
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$143
D4320	Provisional splinting - intracoronal	$75
D4321	Provisional splinting – extracoronal	$75
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$40
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$30
	Removable Prosthodontics	
	● *Replacement limit 1 every 5 years.* ● *Denture relines are limited to 1 every 24 months.* ● *Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$250
D5120	Complete denture – mandibular	$250
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$375
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$375
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$400
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$400
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).	$375
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).	$375
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).	$400
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	$400

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
	rebasing/relining procedure(s).	
D5410	Adjust complete denture – maxillary	$10
D5411	Adjust complete denture – mandibular	$10
D5421	Adjust partial denture – maxillary	$10
D5422	Adjust partial denture – mandibular	$10
D5520	Replace missing or broken teeth – complete denture (each tooth)	$20
D5630	Repair or replace broken retentive clasping materials – per tooth	$45
D5640	Replace broken teeth – per tooth	$20
D5650	Add tooth to existing partial denture	Lab Fee
D5660	Add clasp to existing partial denture - per tooth	Lab Fee
D5730	Reline complete maxillary denture (chairside)	$62
D5731	Reline complete mandibular denture (chairside)	$62
D5740	Reline maxillary partial denture (chairside)	$62
D5741	Reline mandibular partial denture (chairside)	$62
D5750	Reline complete maxillary denture (laboratory)	$75
D5751	Reline complete mandibular denture (laboratory)	$75
D5760	Reline maxillary partial denture (laboratory)	$75
D5761	Reline mandibular partial denture (laboratory)	$75
D5820	Interim partial denture (maxillary)	$90
D5821	Interim partial denture (mandibular)	$90
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$150
	Crowns/Fixed Bridges - Per Unit	
	● *Replacement limit 1 every 5 years.*	
	● *The use of noble or high noble for any procedure will include additional lab fees.*	
	● *Cases involving 5 or more crowns and/or fixed bridge units in the same treatment plan require additional lab fees.*	
	● *$75 fee per crown/bridge unit above co-pay for porcelain on molars.*	
D6205	Pontic - indirect resin based composite	$175
D6210	Pontic – cast high noble metal	$230
D6211	Pontic – cast predominantly base metal	$230
D6212	Pontic – cast noble metal	$230
D6214	Pontic – titanium and titanium alloys	$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
D6243	Pontic – porcelain fused to titanium and titanium alloys	$230
D6710	Crown - indirect resin based composite	$175
D6750	Retainer crown – porcelain fused to high noble metal	$230
D6751	Retainer crown – porcelain fused to predominantly base metal	$230
D6752	Retainer crown – porcelain fused to noble metal	$230
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$230
D6790	Retainer crown – full cast high noble metal	$230
D6791	Retainer crown – full cast predominantly base metal	$230

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D6792	Retainer crown – full cast noble metal	$230
D6794	Retainer crown – titanium and titanium alloys	$230
D6930	Re-cement or re-bond fixed partial denture	$25
	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.*	
D7111	Extraction, coronal remnants – primary tooth	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$14
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$25
D7220	Removal of impacted tooth – soft tissue	$45
D7230	Removal of impacted tooth – partially bony	$55
D7240	Removal of impacted tooth – completely bony	$80
D7250	Removal of residual tooth roots (cutting procedure)	$35
D7280	Exposure of an unerupted tooth	$25
D7283	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	$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	$15
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$20
D7471	Removal of lateral exostosis (maxilla or mandible)	$40
D7472	Removal of torus palatinus	$40
D7473	Removal of torus mandibularis	$40
D7510	Incision and drainage of abscess - intraoral soft tissue	$20
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$20
D7520	Incision and drainage of abscess - extraoral soft tissue	$20
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$20
D7910	Suture of recent small wounds up to 5 cm	$0
	Orthodontics	
	● ***The following orthodontic treatment co-payments apply only when services are performed by your selected SafeGuard general dentist.*** *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. Your co-payments will be 70% of that dentist's usual fees. A listing of contracted orthodontists can be found at www.metlife.com/mybenefits or you may call Customer Service. (See "Orthodontic Exclusions & Limitations" later in this document for further*	

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
	information.)	
D8070	Comprehensive orthodontic treatment of the transitional dentition	30% discount
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,480
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,780
D8660	Pre-orthodontic treatment examination to monitor growth and development	$65
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$60
D8681	Removable orthodontic retainer adjustment	$0
D8698	Re-cement or re-bond fixed retainer – maxillary	$0
D8699	Re-cement or re-bond fixed retainer – mandibular	$0
●	Palatal expansion	$350
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9211	Regional block anesthesia	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9230	Inhalation of nitrous oxide/ anxiolysis, analgesia	$10
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	$20
D9610	Therapeutic parenteral drug, single administration	$3
D9612	Therapeutic parenteral drug, two or more administrations	$13
D9951	Occlusal adjustment – limited	$0
D9952	Occlusal adjustment – complete	$20
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0

DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES

1. Prophylaxis (teeth cleaning) and fluoride treatments are limited to twice a year, unless medically necessary.

2. The use of noble or high noble for any procedure will include additional lab fees.

3. Denture relines are limited to one every twenty four (24) months.

4. Full-mouth X-rays: Once every three (3) years unless medically necessary.

5. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under 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.

6. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

7. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.

8. Cases involving five (5) or more crowns and/or fixed bridge units in the same treatment plan require additional lab fees per unit in addition to copayment for each crown/bridge unit.

9. There is a $75 copayment per crown/bridge unit in addition to regular copayments for porcelain on molars.

10. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.

11. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

12. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.

13. The copayments listed for endodontic procedures do not include the cost of final restoration.

14. Lab Fees - In-lays $97, dentures (upper or lower) $187, partials $193, all removable prosthetic repairs $78, rebase denture (upper or lower) $164, bridges per unit $148, bridge repair per unit $123, biopsy $150, and habit appliance $175.

DENTAL BENEFITS: EXCLUSIONS

1. Services performed by a general dentist or dentist whose practice is limited to providing Specialty Care, not contracted with SafeGuard without prior approval by SafeGuard, (except for out-of area emergency services).

2. 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.

3. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.

5. Orthognathic surgery.

6. General anesthesia or intravenous sedation.

7. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications, except for emergency palliative care.

8. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.

9. Treatment of malignancies, cysts, or neoplasms.

10. 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.

11. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.

12. 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.

13. 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.

14. 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.

15. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or dentist whose practice is limited to Specialty Care in order for the co-payments listed in the Schedule of Benefits to apply. If orthodontic treatment is provided by a SafeGuard contracted dentist whose practice is limited to providing Specialty Care, the copayment will be 70% of the SafeGuard contracted usual and customary fees. If orthodontic treatment is provided by a non-contracted general dentist or dentist whose practice is limited to specialty care, no benefit will apply and the member will be responsible for all costs associated with such orthodontic treatment.

DENTAL BENEFITS: EXCLUSIONS (continued)

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). Changes in treatment necessitated by an accident;
   D). 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.