

Individual & Family

Dental & Vision Plans



SafeGuard
DENTAL & VISION®

Choose the plan that's right for you!

You know how important regular preventive care is for you and your family. Regular dental care and vision exams are an excellent way to ensure wellness and these SafeGuard plans provide excellent benefits at a very reasonable cost.

Take a few minutes to review this information ...

we know you will be pleased with the level of coverage and the amount of money you can save when you enroll in a SafeGuard Dental & Vision Plan.

- No spending maximums
- No deductibles
- No waiting periods
- Each family member may choose a different general dentist from the extensive SafeGuard network
- Discounts on non-covered dental procedures and frames & lenses from SafeGuard providers

HOW THESE PLANS WORK

Dental Benefits

These SafeGuard dental plans cover more than 245 dental procedures. Each plan covers the same procedures, just at different co-payments (a "co-payment" is the amount you pay the dentist for each procedure).

- **SafeGuard's Premier Choice** has lower co-payments* and costs a little more than the other plan option.
- **SafeGuard's Classic Choice** has higher co-payments* but costs you less than the Premier Choice plan.

A Schedule of Benefits for both plans is included here.

*The co-payments listed in the Schedule of Benefits reflect your costs when treatment is performed by your selected SafeGuard general dentist. If you receive care from a SafeGuard network specialty care dentist, your out-of-pocket costs at the time of treatment will be 75% of that dentist's usual fee for that treatment.

Vision Benefits

The SafeGuard vision plan presented here provides an eye exam every 12 months. You may receive this exam from any licensed eye care professional but if you select a SafeGuard provider, you may save on your out-of-pocket costs.

This SafeGuard plan also includes a reduction on frames and lenses when purchased through a network provider. Review the Summary of Benefits in this booklet for full information.

Before you enroll...

- Select a general dentist from the Directory of SafeGuard Participating Dentists
- You and each of your enrolled dependents may select different general dentists

Online Dentist Listing

The most current network information can be found in our online directory at www.safeguard.net.

- Click on "Dental & Vision Directories"
- Choose "Visitor" and then select "Dental HMO" and state.
- Select your plan from the scroll down menu (check the Schedule of Benefits in this booklet for the name of the plan you've chosen). You will be able to search by city, county, ZIP code, or by a particular dentist's name.

Online Vision Listing

You can also find a listing of network vision care professionals online. You do not need to select a vision care provider at enrollment.

After enrollment...

To access the directory once you are enrolled, log in to our website and use your social security number.

If you have any questions, you can call Customer Service at 800.880.1800 or log on to our website at www.safeguard.net/contact.html to email us your questions.

Enrollment Information

Once you've decided on the plan that's right for you, record that information here for future reference:

Chosen Plan Name: _____

Mailed to SafeGuard on _____

Check or Money Order No.: _____

Credit Card Used: _____

SafeGuard® SCHEDULE OF BENEFITS

SELF-REFERRAL DENTAL 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.

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 care giver	\$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 postoperative visit)	\$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	X-rays intraoral - complete series - including bitewings (once every 3 years)	\$0
D0220	X-rays intraoral - periapical - first film	\$0
D0230	X-rays intraoral - periapical - each additional film	\$0
D0240	X-rays intraoral - occlusal film	\$0
D0250	X-rays extraoral - first film	\$0
D0260	X-rays extraoral - each additional film	\$0
D0270	X-rays bitewing - single film	\$0
D0272	X-rays bitewings - two films	\$0
D0273	X-rays bitewings - three films	\$0
D0274	X-rays bitewings - four films	\$0
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	X-rays panoramic film	\$0
D0350	Oral/facial photographic images	\$0

Code	Service	Co-payment
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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 lesions; not to include cytology or biopsy procedures	\$50
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0

Preventive Services

Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.

D1110	Prophylaxis - adult	\$0
D1110	Additional – adult prophylaxis (maximum of two additional per year)	\$35
D1120	Prophylaxis - child	\$0
D1120	Additional – child prophylaxis (maximum of two additional per year)	\$25
D1203	Topical application of fluoride (excluding prophylaxis) - child	\$0
D1204	Topical application of fluoride (excluding prophylaxis) - 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

- 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

Code	Service	Co-payment
D2530	Inlay - metallic - three or more surfaces	\$245
D2543	Onlay - metallic - three surfaces	\$260
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 - 3/4 cast high noble metal	\$245
D2781	Crown - 3/4 cast predominantly base metal	\$245
D2782	Crown - 3/4 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	\$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 build up, 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

All procedures exclude final restoration

D3110	Pulp cap - direct	\$10
D3120	Pulp cap - indirect	\$10
D3220	Therapeutic pulpotomy	\$30
D3221	Pulpal debridement, primary and permanent teeth	\$55
D3230	Pulpal therapy with resorbable filling - primary anterior tooth	\$40
D3240	Pulpal therapy with resorbable filling - primary posterior tooth	\$40
D3310	Root canal - anterior - per tooth	\$110
D3320	Root canal - bicuspid - per tooth	\$185
D3330	Root canal - molar - per tooth	\$265
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$110
D3346	Retreatment of root canal - anterior, per tooth	\$180
D3347	Retreatment of root canal - bicuspid, per tooth	\$280
D3348	Retreatment of root canal - molar, per tooth	\$325
D3351	Apexification/recalcification - initial visit	\$90
D3352	Apexification/recalcification - interim visit	\$90
D3353	Apexification/recalcification - final visit	\$90

Code	Service	Co-payment
D3410	Apicoectomy/periradicular surgery - anterior	\$100
D3421	Apicoectomy/periradicular surgery - bicuspid - 1st root	\$100
D3425	Apicoectomy/periradicular surgery - molar, 1st 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 root removal (excluding 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 teeth, 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 teeth 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 teeth, 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 procedure	\$75
D4274	Distal or proximal wedge procedure - separate procedure	\$100
D4320	Provisional splinting – intracoronal	\$95
D4321	Provisional splinting – extracoronal	\$95
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces - 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 procedures - following active surgery (2 in a 12 month period)	\$40
D4910	Additional periodontal maintenance procedure (beyond 2 per 12 months)	\$55
	Periodontal charting for planning treatment of periodontal disease	\$0
	Periodontal hygiene instruction	\$0

Removable Prosthodontics

- Replacement limit 1 every 5 years.
- Relines are limited to 1 every 12 months.
- Includes up to 3 adjustments within 6 months of delivery.

D5110	Complete upper denture	\$325
D5120	Complete lower denture	\$325
D5130	Immediate upper denture	\$350
D5140	Immediate lower denture	\$350
D5211	Upper partial - resin base (including clasps, rests and teeth)	\$400
D5212	Lower partial - resin base (including clasps, rests and teeth)	\$400
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth)	\$425
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth)	\$425

Code	Service	Co-payment
D5410	Adjust complete denture - upper	\$10
D5411	Adjust complete denture - lower	\$10
D5421	Adjust partial denture - upper	\$10
D5422	Adjust partial denture - lower	\$10
D5510	Repair broken complete denture base	\$35
D5520	Replace missing or broken teeth	\$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 upper denture	\$75
D5711	Rebase complete lower denture	\$75
D5720	Rebase upper partial denture	\$75
D5721	Rebase lower partial denture	\$75
D5730	Reline complete upper denture (chairside)	\$65
D5731	Reline complete lower denture (chairside)	\$65
D5740	Reline upper partial denture (chairside)	\$65
D5741	Reline lower partial denture (chairside)	\$65
D5750	Reline complete upper denture (laboratory)	\$85
D5751	Reline complete lower denture (laboratory)	\$85
D5760	Reline upper partial denture (laboratory)	\$85
D5761	Reline lower partial denture (laboratory)	\$85
D5820	Interim partial denture - upper	\$175
D5821	Interim partial denture - lower	\$175
D5850	Tissue conditioning - upper	\$20
D5851	Tissue conditioning - lower	\$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
D6752	Crown - porcelain fused to noble metal	\$245
D6780	Crown - 3/4 cast high noble metal	\$245
D6781	Crown - 3/4 cast predominantly base metal	\$245
D6782	Crown - 3/4 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

Code	Service	Co-payment
D6794	Crown – titanium	\$245
D6930	Recement bridge	\$15
D6970	Post and core in addition to fixed partial denture retainer, Indirectly fabricated	\$85
D6972	Prefabricated post and core in addition to bridge 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	\$30
D7220	Extraction - removal of impacted tooth - soft tissue	\$50
D7230	Extraction - removal of impacted tooth - partially bony	\$65
D7240	Extraction - removal of impacted tooth - completely bony	\$80
D7241	Extraction - removal of impacted tooth - completely bony, with unusual surgical complications	\$100
D7250	Surgical extraction - removal of residual tooth roots	\$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50
D7280	Surgical exposure of impacted unerupted tooth for orthodontic reasons	\$200
D7285	Biopsy of oral tissue - hard	\$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 – intracoronary soft tissue	\$35
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$50
D7963	Frenuloplasty	\$50
D7971	Excision of pericoronal gingiva	\$40

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

Code	Service	Co-payment
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	Consultation	75% of U&C
D8670	Periodic orthodontic treatment visit (as part of contract)	75% of U&C
D8680	Retention phase (including fee for fixed/removable retainers and monthly visits for 24 months)	75% of U&C
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	75% of U&C
	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	75% of U&C
	Orthodontic 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	Medicinal application/irrigation per visit	\$15
D9940	Occlusal guard, by report	\$85
D9951	Occlusal adjustment - limited	\$30
D9952	Occlusal adjustment - complete	\$100
D9972	External bleaching – per arch	\$125
	Broken appointment (less than 24-hour notice)	Not to exceed \$25

**VISION PLAN**

This vision plan includes in- and out-of-network benefits as listed below; if you visit a network provider, you will receive the maximum benefit. If you choose to see an out-of-network provider, you will be responsible for the co-payment amount listed below. If you choose to see an out-of-network provider, you will be reimbursed the Maximum Benefit Allowance set forth below.

Frequency (months)	Exam
	12

	In-Network Coverage (Using a Network Provider)	Out-of-Network Coverage (Using a Non-Network Provider)
Exam	Your Co-payment \$20	Your Maximum Benefit Allowance \$35 You are responsible for the provider's usual charge; reimbursement for the amount listed will be paid upon receipt of your claim.

Please refer to your Evidence of Coverage for details on the process and administration of your coverage.

Please note:

You are entitled to receive a discount on the following services if they are received by an in-network provider:

Frames: 20% on the participating provider's usual and customary retail fees charged to non-members

Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members

Elective Contact Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members (excluding disposable and frequent replacement contact lenses)

All other non-covered eyewear and options (excluding disposable and frequent replacement contact lenses): 20% on the participating provider's usual and customary retail fees charged to non-members

All other non-covered professional services: 10% on the participating provider's usual and customary retail fees charged to non-members

Benefits provided by SafeGuard Health Plans, Inc.

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

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 or high noble 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.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) month.
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 General Dentist.
3. Delivery of removable prosthodontics 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.

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.

Language Assistance

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at **(800) 880-1800**.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al **(800) 880-1800**.

作為**SafeGuard**的會員，您有權獲得免費語言服務，包括口譯和筆譯。**SafeGuard**收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴**SafeGuard**，可通過電話或網站與**SafeGuard**聯絡，電話是**(800) 880-1800**。

VISION EXCLUSIONS

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 provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
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 provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
4. Orthoptics, vision training and any associated supplemental testing.
5. Medical or surgical treatment of the eye.
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 or furnished 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 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.

SafeGuard® SCHEDULE OF BENEFITS

SELF-REFERRAL DENTAL PLAN

Classic 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.

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 care giver	\$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 postoperative visit)	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	\$0
	Office visit – per visit (including all fees for sterilization and/or infection control)	\$10
Radiographs/Diagnostic Imaging (X-rays)		
D0210	X-rays intraoral - complete series - including bitewings (once every 3 years)	\$0
D0220	X-rays intraoral - periapical - first film	\$0
D0230	X-rays intraoral - periapical - each additional film	\$0
D0240	X-rays intraoral - occlusal film	\$0
D0250	X-rays extraoral - first film	\$0
D0260	X-rays extraoral - each additional film	\$0
D0270	X-rays bitewing - single film	\$0
D0272	X-rays bitewings - two films	\$0
D0273	X-rays bitewings – three films	\$0
D0274	X-rays bitewings - four films	\$0
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	X-rays panoramic film	\$0
D0350	Oral/facial photographic images	\$0

Code	Service	Co-payment
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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 lesions; not to include cytology or biopsy procedures	\$50
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0

Preventive Services

Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.

D1110	Prophylaxis - adult	\$20
D1110	Additional – adult prophylaxis (maximum of two additional per year)	\$45
D1120	Prophylaxis - child	\$20
D1120	Additional – child prophylaxis (maximum of two additional per year)	\$35
D1203	Topical application of fluoride (excluding prophylaxis) - child	\$0
D1204	Topical application of fluoride (excluding prophylaxis) - 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	\$25
D1510	Space maintainer - fixed - unilateral	\$70
D1515	Space maintainer - fixed - bilateral	\$70
D1520	Space maintainer - removable - unilateral	\$80
D1525	Space maintainer - removable - bilateral	\$80
D1550	Recementation of space maintainer	\$20
D1555	Removal of fixed space maintainer	\$20

Restorative Treatment

D2140	Amalgam - one surface, primary or permanent	\$15
D2150	Amalgam - two surfaces, primary or permanent	\$23
D2160	Amalgam - three surfaces, primary or permanent	\$26
D2161	Amalgam - four or more surfaces, primary or permanent	\$28
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	\$70
D2392	Resin-based composite, two surfaces, posterior	\$80
D2393	Resin-based composite, three surfaces, posterior	\$125
D2394	Resin-based composite, four or more surfaces, posterior	\$125

Crowns

- An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 co-payment per 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	\$325
D2520	Inlay - metallic - two surfaces	\$325

Code	Service	Co-payment
D2530	Inlay - metallic - three or more surfaces	\$325
D2543	Onlay - metallic - three surfaces	\$325
D2544	Onlay - metallic - four or more surfaces	\$325
D2610	Inlay – porcelain/ceramic – one surface	\$325
D2620	Inlay – porcelain/ceramic – two surfaces	\$325
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$325
D2740	Crown - porcelain/ceramic substrate	\$275
D2750	Crown - porcelain fused to high noble metal	\$350
D2751	Crown - porcelain fused to predominantly base metal	\$350
D2752	Crown - porcelain fused to noble metal	\$350
D2780	Crown - 3/4 cast high noble metal	\$350
D2781	Crown - 3/4 cast predominantly base metal	\$350
D2782	Crown - 3/4 cast noble metal	\$350
D2790	Crown - full cast high noble metal	\$350
D2791	Crown - full cast predominantly base metal	\$350
D2792	Crown - full cast noble metal	\$350
D2794	Crown – titanium	\$350
D2799	Provisional crown	\$0
D2910	Recement inlay	\$15
D2915	Recement cast or prefabricated post and core	\$15
D2920	Recement crown	\$15
D2930	Prefabricated stainless steel crown - primary tooth	\$55
D2931	Prefabricated stainless steel crown - permanent tooth	\$55
D2940	Sedative filling	\$10
D2950	Core build up, including any pins	\$90
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

All procedures exclude final restoration

D3110	Pulp cap - direct	\$10
D3120	Pulp cap - indirect	\$10
D3220	Therapeutic pulpotomy	\$50
D3221	Pulpal debridement, primary and permanent teeth	\$55
D3230	Pulpal therapy with resorbable filling - primary anterior tooth	\$50
D3240	Pulpal therapy with resorbable filling - primary posterior tooth	\$50
D3310	Root canal - anterior - per tooth	\$240
D3320	Root canal - bicuspid - per tooth	\$250
D3330	Root canal - molar - per tooth	\$375
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$240
D3346	Retreatment of root canal - anterior, per tooth	\$275
D3347	Retreatment of root canal - bicuspid, per tooth	\$325
D3348	Retreatment of root canal - molar, per tooth	\$375
D3351	Apexification/recalcification - initial visit	\$110
D3352	Apexification/recalcification - interim visit	\$110
D3353	Apexification/recalcification - final visit	\$110

Code	Service	Co-payment
D3410	Apicoectomy/periradicular surgery - anterior	\$230
D3421	Apicoectomy/periradicular surgery - bicuspid - 1st root	\$240
D3425	Apicoectomy/periradicular surgery - molar, 1st root	\$275
D3426	Apicoectomy/periradicular surgery - each additional root	\$125
D3430	Retrograde filling - per root	\$75
D3450	Root amputation - per root	\$135
D3920	Hemisection - including root removal (excluding root canal therapy)	\$110

Periodontics

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	\$215
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	\$161
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	\$250
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	\$188
D4249	Clinical crown lengthening - hard tissue	\$290
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	\$395
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	\$296
D4270	Pedicle soft tissue graft procedure	\$300
D4271	Free soft tissue graft procedure (including donor site surgery)	\$310
D4273	Subepithelial connective tissue graft procedure	\$75
D4274	Distal or proximal wedge procedure - separate procedure	\$100
D4320	Provisional splinting – intracoronal	\$95
D4321	Provisional splinting – extracoronal	\$95
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	\$75
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	\$56
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$75
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$75
D4910	Periodontal maintenance procedures - following active surgery (2 in a 12 month period)	\$75
D4910	Additional periodontal maintenance procedure (beyond 2 per 12 months)	\$75
	Periodontal charting for planning treatment of periodontal disease	\$0
	Periodontal hygiene instruction	\$0

Removable Prosthodontics

- *Replacement limit 1 every 5 years.*
- *Relines are limited to 1 every 12 months.*
- *Includes up to 3 adjustments within 6 months of delivery.*

D5110	Complete upper denture	\$525
D5120	Complete lower denture	\$525
D5130	Immediate upper denture	\$525
D5140	Immediate lower denture	\$525
D5211	Upper partial - resin base (including clasps, rests and teeth)	\$485
D5212	Lower partial - resin base (including clasps, rests and teeth)	\$485
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth)	\$575

Code	Service	Co-payment
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth)	\$575
D5410	Adjust complete denture - upper	\$25
D5411	Adjust complete denture - lower	\$25
D5421	Adjust partial denture - upper	\$25
D5422	Adjust partial denture - lower	\$25
D5510	Repair broken complete denture base	\$60
D5520	Replace missing or broken teeth	\$50
D5610	Repair resin denture base	\$60
D5620	Repair cast framework	\$60
D5630	Repair or replace broken clasp	\$85
D5640	Replace broken teeth - per tooth	\$50
D5650	Add tooth to existing partial denture	\$70
D5660	Add clasp to existing partial denture	\$85
D5710	Rebase complete upper denture	\$205
D5711	Rebase complete lower denture	\$205
D5720	Rebase upper partial denture	\$190
D5721	Rebase lower partial denture	\$190
D5730	Reline complete upper denture (chairside)	\$120
D5731	Reline complete lower denture (chairside)	\$120
D5740	Reline upper partial denture (chairside)	\$110
D5741	Reline lower partial denture (chairside)	\$110
D5750	Reline complete upper denture (laboratory)	\$155
D5751	Reline complete lower denture (laboratory)	\$155
D5760	Reline upper partial denture (laboratory)	\$155
D5761	Reline lower partial denture (laboratory)	\$155
D5820	Interim partial denture - upper	\$190
D5821	Interim partial denture - lower	\$205
D5850	Tissue conditioning - upper	\$50
D5851	Tissue conditioning - lower	\$50

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	\$350
D6211	Pontic - cast predominantly base metal	\$350
D6212	Pontic - cast noble metal	\$350
D6214	Pontic - titanium	\$350
D6240	Pontic - porcelain fused to high noble metal	\$350
D6241	Pontic - porcelain fused to predominantly base metal	\$350
D6242	Pontic - porcelain fused to noble metal	\$350
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$265
D6721	Crown - resin with predominantly base metal	\$350
D6750	Crown - porcelain fused to high noble metal	\$350
D6751	Crown - porcelain fused to predominantly base metal	\$350
D6752	Crown - porcelain fused to noble metal	\$350
D6780	Crown - 3/4 cast high noble metal	\$350
D6781	Crown - 3/4 cast predominantly base metal	\$350
D6782	Crown - 3/4 cast noble metal	\$350

Code	Service	Co-payment
D6790	Crown - full cast high noble metal	\$350
D6791	Crown - full cast predominantly base metal	\$350
D6792	Crown - full cast noble metal	\$350
D6794	Crown – titanium	\$350
D6930	Recement bridge	\$35
D6970	Post and core in addition to fixed partial denture retainer, Indirectly fabricated	\$85
D6972	Prefabricated post and core in addition to bridge 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)	\$20
D7210	Surgical removal of erupted tooth	\$60
D7220	Extraction - removal of impacted tooth - soft tissue	\$60
D7230	Extraction - removal of impacted tooth - partially bony	\$80
D7240	Extraction - removal of impacted tooth - completely bony	\$160
D7241	Extraction - removal of impacted tooth - completely bony, with unusual surgical complications	\$180
D7250	Surgical extraction - removal of residual tooth roots	\$55
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$95
D7280	Surgical exposure of impacted unerupted tooth for orthodontic reasons	\$200
D7285	Biopsy of oral tissue - hard	\$180
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	\$50
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$25
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$140
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$75
D7510	Incision and drainage of abscess – intracoronal soft tissue	\$35
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$110
D7963	Frenuloplasty	\$110
D7971	Excision of pericoronal gingiva	\$40

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

Code	Service	Co-payment
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	Consultation	75% of U&C
D8670	Periodic orthodontic treatment visit (as part of contract)	75% of U&C
D8680	Retention phase (including fee for fixed/removable retainers and monthly visits for 24 months)	75% of U&C
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	75% of U&C
	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	75% of U&C
	Orthodontic 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	\$15
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	Medicinal application/irrigation per visit	\$20
D9940	Occlusal guard, by report	\$85
D9951	Occlusal adjustment - limited	\$30
D9952	Occlusal adjustment - complete	\$100
D9972	External bleaching – per arch	\$125
	Broken appointment (less than 24-hour notice)	Not to exceed \$25



SafeGuard[®] SUMMARY OF BENEFITS

VISION PLAN

This vision plan includes in- and out-of-network benefits as listed below; if you visit a network provider, you will receive the maximum benefit. If you choose to see an out-of-network provider, you will be responsible for the co-payment amount listed below. If you choose to see an out-of-network provider, you will be reimbursed the Maximum Benefit Allowance set forth below.

Frequency (months)	Exam
	12

	In-Network Coverage (Using a Network Provider)	Out-of-Network Coverage (Using a Non-Network Provider)
Exam	Your Co-payment \$20	Your Maximum Benefit Allowance \$35 You are responsible for the provider's usual charge; reimbursement for the amount listed will be paid upon receipt of your claim.

Please refer to your Evidence of Coverage for details on the process and administration of your coverage.

Please note:

You are entitled to receive a discount on the following services if they are received by an in-network provider:

Frames: 20% on the participating provider's usual and customary retail fees charged to non-members

Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members

Elective Contact Lenses: 20% on the participating provider's usual and customary retail fees charged to non-members (excluding disposable and frequent replacement contact lenses)

All other non-covered eyewear and options (excluding disposable and frequent replacement contact lenses): 20% on the participating provider's usual and customary retail fees charged to non-members

All other non-covered professional services: 10% on the participating provider's usual and customary retail fees charged to non-members

Benefits provided by SafeGuard Health Plans, Inc.

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

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 or high noble 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.

Prosthodontics

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 General Dentist.
3. Delivery of removable prosthodontics 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.

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.

Language Assistance

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at **(800) 880-1800**.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al **(800) 880-1800**.

作為**SafeGuard**的會員，您有權獲得免費語言服務，包括口譯和筆譯。**SafeGuard**收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴**SafeGuard**，可通過電話或網站與**SafeGuard**聯絡，電話是**(800) 880-1800**。

VISION EXCLUSIONS

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 provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
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 provide these services with discounts of ten percent (10%) to twenty percent (20%) on the participating provider's usual and customary retail fees charged to non-members for those materials.
4. Orthoptics, vision training and any associated supplemental testing.
5. Medical or surgical treatment of the eye.
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 or furnished 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 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.



**Combined
Evidence of Coverage
and Disclosure Form
Individual Dental
and Vision Plan**

Benefits provided by SafeGuard Health Plans, Inc.

Dental and Vision Evidence of Coverage and Disclosure Statement

This Individual Membership contract and Evidence of Coverage, along with the Schedule of Benefits, provides a complete description of how your SafeGuard Dental and Vision Plan operates, your entitlements and the Plan's restrictions and limitations.

This combined Evidence of Coverage and Disclosure Statement constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

You may obtain a copy of the health plan contract by requesting it from SafeGuard in writing at PO Box 3594, Laguna Hills, California 92654-3594 or by calling (800) 880-1800.

This Evidence of Coverage and Disclosure Statement is subject to Chapter 2.2. of Division 2 of the California Health and Safety Code (commonly referred to as the Knox-Keene Act) and the regulations issued thereto by the Department of Managed Health Care. Should either the law or the regulations be amended, such amendments shall automatically be deemed to be a part of this document and shall take precedence over any inconsistent provision of this contract. Any provision required to be in this Evidence of Coverage and Disclosure Statement by either law or the regulation shall automatically bind SafeGuard.

Entire Contract

SafeGuard typically contracts directly with an individual, such as you to provide benefits. Your application, Enrollment Form, this Evidence of Coverage and any attachments or inserts including the Schedule of Benefits with Exclusions and Limitations, constitutes the entire agreement between the parties. To be valid, any change in the contract must be approved by an officer of SafeGuard and attached to it. No agent may change the Contract or waive any of the provisions. Should any provision herein not conform to applicable laws, it shall be construed as if it were in full compliance thereof.

If any provision of this contract is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this contract, but such remaining provisions shall continue in full force and effect unless the illegality and invalidity prevent the accomplishment of the objectives and purposes of this contract.

A STATEMENT DESCRIBING SAFEGUARD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF DENTAL AND VISION RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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Who May Enroll

You may enroll yourself and your dependents, provided each meets eligibility requirements and/or the **Service Area** and **Dependent Coverage** requirements listed below.

Service Area

The Service Area is the geographical area in which SafeGuard has a panel of Selected General Dentists and Specialists and contracted Vision Care Providers who have agreed to provide care to SafeGuard members. To enroll in the SafeGuard Plan, you must reside, live, or work in the Service Area and the permanent legal residence of any enrolled dependents must be:

- The same as yours;
- In the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where the Subscriber has legal responsibility for the health care of such dependents;
- In the Service Area under other circumstances where you are legally responsible for the health care of such dependents; or
- In the service area with your Spouse.

Dependent Coverage

SafeGuard defines eligible dependents to be:

- Your lawful spouse or registered domestic partner;
- Your unmarried children or grandchildren through age 25 for whom you provide care (including adopted children, step-children, or other children for whom you are required to provide dental care pursuant to a court or administrative order);
- Your children who are incapable of self-sustaining employment and support due to a developmental disability or physical handicap and who are dependent on you for their support and maintenance.

You must furnish SafeGuard with proof of dependent status, as provided by law.

Please check with SafeGuard if you have questions regarding your eligibility requirements.

When Coverage Begins

Coverage will begin for you and your enrolled dependents on the first day of the month following the date your premium payment is received by SafeGuard. Newborn children are covered the first day of the month following the date of

birth and legally adopted children, foster children and step-children are covered the first day of the month following placement, as long as SafeGuard is notified within thirty (30) days and any Prepayment Fee (also known as premium payment) is paid within that period. Check with SafeGuard if you have any questions about when your coverage begins.

Choice of Dental or Vision Provider

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL AND/OR VISION CARE MAY BE OBTAINED

Choice of Dental Provider

When you enroll in the SafeGuard Plan, you and each enrolled family member must choose a Selected General Dental Office from our SafeGuard network. Each family member may select a different dental office. Please refer to the **Directory of Participating Dentists** for a complete listing of Selected General Dental Offices. Or you may access our website at **www.safeguard.net** to view SafeGuard General Dentists in your home or work zip codes. The dentists in the directory may not accept all plans. Please check with your Selected General Dental Office to verify that your plan is accepted.

Choice of Vision Provider

If you want 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, your specific benefits will be those noted as In-Network Coverage on the Schedule of Benefits. You may obtain a Vision Care Provider Directory by calling our Customer Service Department at (800) 880-1800 or by visiting **www.safeguard.net**.

If you wish to see a licensed provider not listed in our directory for covered vision services, you may do so. By receiving services from an out-of-network provider, your specific benefits will be those noted as Out-of-Network Coverage on the Schedule of Benefits and may be less than you would receive from an in-network vision provider.

Facilities

A complete list of contracted facilities is contained in the Directory of Participating Dentists and/or the Directory of Participating Vision Care Providers.

Provider Reimbursement

By statute, every contract between SafeGuard and its providers state that, in the event SafeGuard fails to pay the provider, the member shall not be liable to the provider for any sums owed by the plan. If you receive services from a

non-contracted provider, you may be liable to the non-contracted provider for the cost of services rendered. If you receive emergency services from a non-contracted provider, you are entitled to reimbursement, subject to the Emergency Services Reimbursement provision of this Evidence of Coverage.

Participating General Dentists are compensated through a combination of per member, per month payments (or “capitated” basis) and may receive an additional fee for certain procedures performed (supplemental payments). Dental specialists are compensated on a discounted fee for service basis. No bonuses or incentives are paid to participating Dental Providers.

Participating Vision Care Providers will collect all applicable co-payments from you directly at the time of service and then bill SafeGuard for reimbursement according to contracted plan provisions, if applicable.

SafeGuard compensates its participating Vision Care Providers on a discounted fee for service basis. No bonuses or incentives are paid to participating Vision Care Providers.

For additional information you may contact SafeGuard at (800) 880-1800 or speak directly with your provider.

New Patient and Routine Services **Making a Dental Appointment**

As a SafeGuard member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the Selected General Dentist may need additional time to meet your special request.

Once your coverage begins, you may contact the Selected General Dental Office you selected at enrollment to schedule an appointment. SafeGuard Selected General Dental Offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as a SafeGuard member. Your Selected General Dental Office will also need to know your chief dental concern and basic personal data.

Arrive early for your first appointment to complete any paperwork. There is an office visit co-payment on some plans and a charge for missing your appointments. Your first visit to your Selected General Dentist will usually consist of X-rays and an examination only. By performing these procedures first, your dentist can establish your treatment plan according to your overall health needs.

We recommend you take this booklet with you on your appointment, along with the enclosed Schedule of Benefits. Remember, only dental services

listed as covered benefits in the Schedule of Benefits and provided by a SafeGuard Dentist are covered.

Making a Vision Appointment

Once your coverage begins, you may contact the vision provider of your choice to schedule an appointment. SafeGuard Participating Vision Care Provider Offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as a SafeGuard member.

Uniform Health Plan Benefits and Coverage Matrix

This matrix is designed to help you compare covered benefits and is a summary only. Please review this Evidence of Coverage and the Schedule of Benefits for a detailed description of covered benefits, exclusions and limitations.

Category	Vision Co-payments and Limitations	Dental Co-Payments and Limitations
Deductibles	None	None
Lifetime Maximums	None	None
Professional Services	Eye Exam: In-Network \$20; Out-of-Network \$35 You are entitled to receive a discount on the following services if they are rendered by an in-network provider: Frames: 20% discount on the provider's usual and customary retail fees charged to non-members; Lenses: 20% discount on the provider's usual and customary retail fees charged to non-members; Elective Contact Lenses (excluding disposable and frequent replacement contact lenses): 20% discount on the provider's usual and customary retail fees charged to non-members; All other non-covered eyewear and options	All co-payments are listed on the Schedule of Benefits.

	(excluding disposable and frequent replacement contact lenses): 20% discount on the provider's usual and customary retail fees charged to non-members; All other non-covered professional services (excluding disposable and frequent replacement contact lenses): 10% discount on the provider's usual and customary retail fees charged to non-members.	
Emergency Health Coverage	\$35	\$50
Ambulance Services	None	None
Prescription Drug Coverage	None	None
Durable Medical Equipment	None	None
Mental Health Services	None	None
Chemical Dependency Services	None	None
Home Health Services	None	None
Other	Please review your plan's Schedule of Benefits for more details on covered services.	Please review your plan's Schedule of Benefits for more details on covered services.

Referrals for Dental Specialty Care

You may choose to receive benefits from any SafeGuard contracted specialty care provider. A list may be found online at www.safeguard.net or you may call Customer Service (800-880-1800) for assistance. Treatment by a non-participating dentist or Specialist will not be covered. Specialists are available only when the dental procedure cannot be performed by the Selected General Dentist due to the severity of the problem and when they are performed by a SafeGuard contracted provider whose practice is limited to specialty care. Fees will be seventy-five percent (75%) of the Specialist's usual and customary fees and paid by the member.

Referrals for Vision Specialty Care

You may choose to receive benefits from any SafeGuard vision provider, including contracted ophthalmologists. A list of SafeGuard participating vision care providers may be found online at www.safeguard.net or you may call 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 your *Vision Schedule of Benefits*. Vision specialty care is not a covered service. If, in the opinion of the Vision Care Provider, it is in the best interest of the Member to be referred to an ophthalmologist or specialist for specialty services that are not covered by the Plan, you will be responsible for the fee-for-service charges for non-covered services. You are advised to refer to your medical coverage to evaluate if coverage exists for any specialty care treatment that may be required.

Authorization and Referral Process

Upon request, SafeGuard will make available to all members, a description of the authorization and referral process for services or a description of the process used to analyze the qualifications and credentials of providers under contract with SafeGuard.

Changing your SafeGuard Selected General Dentist

You have control over the choice of Selected General Dental Office, and you can request changes at any time. If you need or desire to change your Selected General Dental Office, please contact Customer Service at **(800) 880-1800**. Our associates will help you locate a Selected General Dental Office most convenient to you. The transfer will be effective on the first day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your X-rays and dental records.

Changing your SafeGuard Vision Care Provider

You may choose to receive benefits from any Vision Care Provider. Contracted Vision Care Providers in the SafeGuard directory may not accept all plans. Please check with your Vision Care Provider Office to verify that your plan is accepted.

Customer Service

SafeGuard provides toll-free access to our Customer Services Associates to assist you with benefit coverage questions, resolving problems, changing your Selected General Dentist, or locating a Contracted Vision Care Provider. SafeGuard's Customer Service can be reached Monday through Friday at **(800) 880-1800** from 5:00 am to 6:00 pm, Pacific Time. Automated service is also provided after hours for eligibility verification and dental office transfers.

Second Opinions for Dental or Vision Services

At no cost to you, a second opinion may be requested if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental or vision treatment. Contact SafeGuard's Customer Service Department either by calling **(800) 880-1800** or sending a written request to the following address:

**California:
SafeGuard
c/o Customer Service
PO Box 3594
Laguna Hills, CA 92654-3594**

In addition, your Selected General Dentist, contracted Vision Care Provider, or SafeGuard may also request a second opinion on your behalf. There is no second opinion consultation charge to you. You will be responsible for the office visit co-payment as listed on your Dental or Vision *Schedule of Benefits*.

Reasons for a second opinion to be provided or authorized shall include, but are not limited to the following:

- (1) If you question the reasonableness or necessity of recommended surgical procedures.
- (2) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- (3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

- (4) If the treatment plan in progress is not improving your dental or vision condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuation of the treatment.

All requests for second opinion are processed within five (5) business days of receipt by SafeGuard of such request except when an expedited second opinion is warranted; in which case a decision will be made and conveyed to you within 24 hours. Upon approval, SafeGuard will contact the consulting dentist or vision care provider and make arrangements to enable you to schedule an appointment. All second opinion consultations will be completed by a SafeGuard Contracting Dentist or Vision Care Provider with qualifications in the same area of expertise as the referring provider or the provider who provided the initial examination or services. You may obtain a copy of the second dental or vision opinion policy by contacting SafeGuard's Customer Service Department by telephone at the toll-free number indicated previously, or by writing to SafeGuard at the above address.

No co-payment is required for a second opinion consultation. Some plans do require a co-payment for an office visit.

Your Financial Responsibility

Prepayment Fees

You are responsible for paying SafeGuard for your coverage on a monthly or annual basis, as may be applicable. The Prepayment Fee (also known as "premium payment") is not the same as a co-payment. Your prepayment fees are set forth on your enrollment form. Your prepayment fees will not be changed during the initial term of your coverage, but may be changed, upon notice to you by SafeGuard, upon renewal.

Dental Co-payments

When you receive care from a Selected General Dentist, you will pay the co-payment described on your Schedule of Benefits enclosed with this Evidence of Coverage. When you are referred to a Specialist, your co-payment is seventy five percent (75%) of the dentist's usual fee. Please refer to the Schedule of Benefits for specific details. When you have paid the required co-payment, if any, you have paid in full. SafeGuard's Selected General Dentists have agreed to look only to SafeGuard and not to its enrollees for payment of covered services. If SafeGuard fails to pay the contracted provider, you will not be liable to the provider for any sums owed by SafeGuard. If you choose to receive services from a non-contracted provider, you may be liable to the non-contracted provider for the cost of services unless specifically authorized by SafeGuard or in accordance with emergency care provisions. **SafeGuard does not require claim forms.**

Plan benefits will be based on the most current dental terminology. From time to time, SafeGuard reserves the right to update the plan to reflect the most current dental terminology.

Vision Co-payments

The Vision benefits available under your plan are set forth in the Schedule of Benefits. If you receive an examination from a contracted (in-network) vision care provider, your copayment for such examination will be twenty dollars (\$20) as shown in your Schedule of Benefits. If you receive an examination from an out-of-network vision care provider, you are entitled to receive the thirty-five dollar (\$35) Maximum Benefit Allowance shown in your Schedule of Benefits. See your Schedule of Benefits for more information.

Certain covered charges may be payable under the Plan 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 Schedule of Benefits. It is your responsibility to determine if a Vision Care Provider is a contracted (in-network) provider at the time that the service or material is provided.

Covered Vision Services and Materials

The following will be covered benefits under the Plan:

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

Corrective lenses, frames, and contact lenses are not covered under the Plan. If you choose to purchase these materials from a contracted vision provider, you will receive a ten percent (10%) to twenty percent (20%) discount on the contracted vision provider's usual and customary retail fees charged to non-members for those materials. If you choose 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 Schedule of Benefits for the Exclusions and Limitations applicable to your plan.

Other Charges

All other charges you may be required to pay under this plan are listed in the Schedule of Benefits.

Coordination of Benefits

If you are covered for benefits by more than one plan, SafeGuard will always pay eligible benefits as the primary plan without regard to payments to be made by another plan.

There are no restrictions on the assignment of sums payable to the member by SafeGuard.

General Provisions: Notice and Proof of Claim

Written notice of any claim must be given to SafeGuard within 90 days after the occurrence or commencement of any covered loss (or 180 days if services are received by a non-contracted Provider), or as soon thereafter as reasonably possible. Notice may be given to SafeGuard Dental & Vision, 95 Enterprise, Suite 100, Aliso Viejo, CA 92656.

Upon enrollment SafeGuard will furnish you with forms for filing proof of loss. If SafeGuard does not furnish you with the usual form, you can comply with the requirements for furnishing proof of loss by giving written proof. Such written proof must cover the occurrence, the character and the extent of the loss. **SafeGuard does not require claim forms.**

Eligibility of Medicaid Not Considered

SafeGuard shall not consider the availability or eligibility for medical assistance under Medicaid, when considering eligibility for coverage or making payments under this Policy.

Payment of Vision Claims

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

Emergency Services

Emergency services are dental or vision procedures administered in a dentist's office, dental clinic, vision care provider's office, or other comparable facility, to evaluate and stabilize dental or vision conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a reasonably prudent lay person possessing average knowledge of dentistry or vision care to believe that immediate care is needed.

HOW TO OBTAIN EMERGENCY DENTAL OR VISION CARE OR SERVICES

All Selected General Dental Offices and/or Contracted Vision Care Providers provide Emergency Services twenty-four (24) hours a day, seven (7) days a week and SafeGuard encourages you to seek care from your Selected General Dentist or Vision Care Provider. **If you require emergency dental or vision services, you may go to any dental or vision provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior Authorization for emergency dental or vision services is not required.**

If you do not require Emergency Dental or Vision Care or Emergency Dental or Vision Services, which a reasonable person under the same circumstances would believe were warranted, and a delay in receiving treatment would not be detrimental to your health, please contact your Selected General Dentist or your Vision Care Provider (as applicable) or SafeGuard at (800) 880-1800 to make reasonable arrangements for your care.

Reimbursement Provisions

Your reimbursement from SafeGuard for emergency dental or vision services, if any, is limited to the extent the treatment you received directly relates to emergency dental or vision services – i.e., to evaluate and stabilize the dental or vision condition. All reimbursements will be allocated in accordance with your plan benefits, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any hospital or outpatient care facilities that are not related to the actual dental or vision condition are not covered benefits.

If you receive emergency dental or vision services from a provider other than your Selected General Dentist or Contracted Vision Care Provider, you will be required to pay the charges to the dentist or vision care provider and submit a claim to SafeGuard for a benefits determination. If you seek emergency dental services from a provider located more than 25 miles away from your Selected General Dentist, you will receive emergency benefits coverage up to a maximum of \$50, less any applicable co-payments. If you seek emergency services from a non-contracted vision care provider located more than 25 miles from the service area, you will receive emergency benefits coverage up to a maximum of \$35 for all emergency care rendered during a contract year, less any applicable co-payments.

To be reimbursed for emergency dental or vision services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement. In the event of a dental emergency and you are within twenty-five (25) miles of your Selected General Dental Office or Vision Care Provider's office, simply contact your dentist or vision care provider who will make reasonable arrangements for such emergency dental or vision care. If your dentist or vision care provider isn't available, you must contact SafeGuard's Customer Service Department at (800) 880-1800 for assistance.

If you are more than twenty-five (25) miles from your chosen Selected General Dental Office or the vision service area, or you cannot reach your dentist or vision care provider or SafeGuard's Customer Service, you may obtain emergency dental or vision services from any licensed dentist or vision care provider. To

be reimbursed for a dental or vision emergency, you must notify Customer Service within forty-eight (48) hours after receiving dental or vision emergency care services. If your physical condition does not permit such notification within the prescribed time, the member must make the notification as soon as it is reasonably possible to do so.

Decisions relating to payment or denial of the reimbursement request will be made within thirty (30) business days of the date of all information reasonably required to render such decision is received by SafeGuard.

Grievance Procedures

If you or one of your eligible dependents has a grievance with us, your dentist, or your vision care provider you may orally submit such grievance by calling our Customer Service Department at (800) 880-1800. We will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number) or a detailed summary of your grievance to:

**SafeGuard
c/o Quality Management Department
PO Box 3532
Laguna Hills, CA 92654-3532**

You may also file a written grievance via our website at www.safeguard.net. Please click on members, then Forms to Print, and then Grievance Forms.

Please be sure to include your name (patient's name, if different), Member Identification Number, facility (or Selected General Dental Office or Vision Care Provider) name and number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the plan. We will confirm receipt of your complaint in writing within five (5) calendar days of receipt. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-880-1800 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving

an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions by a health plan related to the medical necessity of a proposed or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

In the event of an urgent grievance, which involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, you are not required to participate in SafeGuard's grievance process and may directly contact the California Department of Managed Health Care, as referenced above, for review of the urgent grievance.

Arbitration

Each and every disagreement, dispute or controversy, which remains unresolved, concerning the construction, interpretation, performance or breach of this Contract, or the provision of dental or vision services under this contract after exhausting SafeGuard's Grievance Procedures, arising between the Organization, a member, or the heir-at-law or personal representative of such person, as the case may be, and SafeGuard, its employees, officers or directors, or participating dentist or their dental groups, contracted vision care providers, partners, agents, or employees, may be voluntarily submitted to arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability and malpractice, that is as to whether any dental or vision services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this Contract, but which gives rise to a claim after the termination of this Contract. Arbitration shall be initiated by written notice to the President, SafeGuard Health Plans, Inc., PO Box 30900, Laguna Hills, California 92654-0900. The notice shall include a detailed description of the matter to be arbitrated.

Changes to Your Coverage

Termination of Benefits

Your coverage may be cancelled for any reason, after not less than sixty (60) days written notice by either you or SafeGuard.

Your coverage may be cancelled after not less than thirty (30) days written notice for:

- Non-payment of amounts due under the contract, except no written notice will be required for failure to pay premium.
- Failure to establish a satisfactory dentist patient relationship and if it is shown that SafeGuard has, in good faith, provided you with the opportunity to select an alternative dentist.
- Neither residing, living, or working in the service area or area for which SafeGuard is authorized to do business.

Your coverage may be cancelled after not less than 15 days written notice for:

- An intentional misrepresentation, except as limited by statute.
- Fraud in the use of services or facilities.
- Such other good cause as is agreed upon in the contract.

Your coverage may be cancelled immediately:

- Subject to continuation of coverage and conversion privilege provisions, if applicable, if you do not meet eligibility requirements other than the requirements that you live or work in the service area.
- For any misconduct detrimental to safe plan operations and the delivery of services.

If you fail to pay the prepayment fees through and including the final month of the contract, all coverage may be terminated at the end of the grace period, and you may be responsible for the usual fees for any services received from your Selected General Dentist or Specialist or Vision Care Provider during the period the prepayment fees went unpaid, including the grace period.

Enrollment will be cancelled as of the last day for which payment has been received, subject to compliance with notice requirements.

If you terminate from the Plan while dental or vision care is being provided to you, your dentist or Contracted Vision Care Provider must complete any treatment started on you before your termination, abiding by the terms and conditions of the Plan.

Orthodontic treatment is governed by the orthodontic limitations listed on your Schedule of Benefits. If you terminate coverage from the plan after the start of orthodontic treatment, you will be responsible for any additional incurred charges for any remaining orthodontic treatment.

Renewal Provisions

You have contracted with SafeGuard to provide services for the time period specified in the contract. Your coverage under the plan is guaranteed for that time period so long as you meet the eligibility requirements under the plan. When the contract expires, it may be renewed. If renewed, it is possible that the terms of the plan may have been changed. If changes to benefits, co-payments or premiums have been made to a renewed contract, you will be notified not less than thirty (30) days before the effective date of the change.

Reinstatement

Receipt by SafeGuard of the proper prepaid or periodic payment after cancellation of the contract for non-payment shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding payment.

An enrollee or subscriber who alleges that his or her enrollment has been canceled or not renewed because of his or her health status or requirements for health care services may request a review by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists, the Director shall notify SafeGuard. Within 15 days after receipt of such notice, SafeGuard shall either request a hearing or reinstate the enrollee or subscriber. If, after a hearing, the Director determines that the cancellation or failure to renew is improper, the Director shall order SafeGuard to reinstate the enrollee or subscriber. A reinstatement pursuant to this provision shall be retroactive to the time of cancellation or failure to renew and SafeGuard shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

Cancellation of Benefits

If the required premium is not paid, your coverage may be terminated. If any applicable Prepayment Fee due from you is not paid timely, your benefits may be canceled not less than thirty-one (31) days after such Prepayment Fee was due. Your coverage may be canceled by SafeGuard upon fifteen (15) days written notice for fraud or misrepresentation or fraud in use of services or facilities. In the absence of fraud, all statements made by a Subscriber are considered representations and not warranties.

During the first two (2) years, coverage can be voided for a material misrepresentation contained in the Enrollment Form. After two (2) years, coverage can be voided only in the event of a fraudulent misstatement contained in the Enrollment Form. Coverage may be canceled immediately in the case of misconduct which is detrimental to safe plan operations and the delivery of services. If you and your dentist fail to establish a satisfactory patient-dentist relationship, you may transfer to another Selected General Dental Office to provide for continued coverage under the Plan. You may receive vision care from any Vision Care Provider. SafeGuard reserves the right to terminate a member's enrollment in SafeGuard if the member is unable to establish and maintain a satisfactory doctor/patient relationship with a dentist. Reasons for proceeding with termination include, but are not limited to, threats or actual physical abuse, theft from the dental office, deceit or forgery, property damage, or harassment. SafeGuard established a fair process for review and determination of such issues.

Your coverage may be cancelled for reasons other than for non-payment of premium or termination of eligibility, with forty five (45) days written notice. The only versions for cancellation at such time other than the renewed period (other than for nonpayment of premium or termination of eligibility) shall be as follows: 1) your behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that your continued participation seriously impairs SafeGuard's ability to provide services to other members; 2) fraud or material misrepresentation in applying for or presenting any claim for benefits under contract; 3) misuse of this Evidence of Coverage; or 4) furnishing SafeGuard with incorrect or incomplete information for the purposes of fraudulently obtaining services.

Pursuant to Section 1365(b) of the Knox-Keene Act, any Member who alleges his/her enrollment has been canceled or not renewed because of his/her health status or requirements for services may request review by the Director of the Department of Managed Health Care

Termination of Contract

Your contract with SafeGuard is for a period of twelve (12) months and automatically renews as described previously. If your contract is terminated, your membership in the Plan will be terminated. In the event of contract termination, no further benefits will be provided to you and none of the Plan provisions will apply. If you fail to pay the Prepayment Fees through and including the final month of the contract, all coverage may be terminated at the end of the grace period, and you may be responsible for the usual fees for any services received from your Selected General Dentist or specialist or Vision Care Provider during the period the Prepayment Fees went unpaid, including the grace period.

Extension of benefits will be until the completion of the procedure in process, or ninety (90) days, whichever is sooner.

Incontestability

All statements made on your Enrollment Form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of your knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew your coverage or reduce benefits unless: (1) it is in a written enrollment application signed by you; and (2) a signed copy of the enrollment application is or has been furnished to you or your representative. This contract may only be contested for fraud or intentional misrepresentation of material fact made on the enrollment application.

The statements and information contained in the Member's Enrollment Form are represented by Member to be true and correct and incorporated into this contract. The member also recognizes that SafeGuard has issued this contract in reliance on those statements and information. This contract replaces and cancels all other contracts, if any, issued to the Member.

Continuity of Care **Current Members**

Current members may have the right to the benefit of completion of care with their Terminated Provider for certain specified dental conditions. Please call SafeGuard at (800) 880-1800 to see if you may be eligible for this benefit. You may request a copy of SafeGuard's Continuity of Care Policy. You must make a specific request to continue under the care of your Terminated Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Terminated Provider on the terms regarding your care in accordance with California law.

New Members

New members may have the right to the benefit of completion of care with their Non-Participating Provider for certain specified dental conditions. Please call SafeGuard at (800) 880-1800 to see if you may be eligible for this benefit. You may request a copy of SafeGuard's Continuity of Care Policy. You must make a specific request to continue under the care of your Non-Participating Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Non-Participating Provider on the terms regarding your care in accordance with California law. This policy does not apply to new members of an individual subscriber contract.

Conversion Privilege/Continuation of Coverage

Contact SafeGuard's Customer Service at (800) 880-1800 to check availability of a Plan in your area and for further information and details.

Member Rights

During the term of the contract between SafeGuard and you, SafeGuard guarantees that it will not decrease any benefits; increase any co-payment; or materially change any Limitation or Exclusion. SafeGuard will not cancel or fail to renew your enrollment in this Plan because of your health condition or your requirements for dental care. Your Selected General Dental Office or Vision Care Provider is responsible to you for all treatment and services, without interference from SafeGuard.

However, your Selected General Dentist or Contracted Vision Care Provider must follow the rules and limitations set up by SafeGuard and conduct his or her professional relationship with you within the guidelines established by SafeGuard. If SafeGuard's relationship with your Selected General Dentist or Contracted Vision Care Provider ends, your dentist or vision care provider is obligated to complete any and all treatment in progress. SafeGuard will arrange a transfer for you to another dentist or vision care provider, as applicable, to provide for continued coverage under the Plan. As indicated on your Enrollment Form, your signature authorizes SafeGuard to obtain copies of your dental or vision records if necessary.

As a member, you have the right to:

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality;
- Express grievances and be informed of the grievance process;
- Have access and availability to care and access to copies of your dental or vision records;
- Participate in decision-making regarding your course of treatment;
- Be provided information regarding Selected General Dental Offices and Contracted Vision Care Providers; and
- Be provided information regarding the services, benefits and specialty referral process provided by SafeGuard.

Member Responsibilities

If you continually refuse a prescribe course of treatment, use the professional relationship for illegal means, or abuse the professional relationship, your Selected General Dentist or Dentist whose practice is limited to Specialty Care has the right to refuse to treat you. If you receive dental or vision care

during a time you are not eligible under the Plan, you will be responsible to pay the dentist or vision care provider the usual fee for that care. You have the responsibility to pay the co-payment associated with specific procedures you may undergo in the course of your treatment.

As a member, you have the responsibility to:

- Identify yourself to your Selected General Dental Office or Contracted Vision Care Provider as a SafeGuard member. If you fail to do so, you may be charged the provider's usual and customary fees instead of the applicable co-payment, if any.
- Treat the Selected General Dentist and/or Contracted Vision Care Provider, office staff and SafeGuard staff with respect and courtesy and cooperate with the prescribed course of treatment. If you continually refuse a prescribed course of treatment, your Selected General Dentist or Specialist has the right to refuse to treat you. SafeGuard will facilitate second opinions and will permit you to change your Selected General Dental Office; however, SafeGuard will not interfere with the provider-patient relationship and cannot require a particular provider to perform particular services.
- Keep scheduled appointments or contact the dental or vision care office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.
- Make co-payments at the time of service. If you do not, the dentist or contracted vision care provider may collect those co-payments from you at subsequent appointments and in accordance with their policies and procedures.
- Notify SafeGuard of changes in family status. If you do not, SafeGuard will be unable to authorize dental or vision care for you and/or your family members.

Confidentiality of Dental and/or Vision Records

A STATEMENT DESCRIBING SAFEGUARD'S POLICIES AND PROCEDURES REGARDING THE CONFIDENTIALITY OF DENTAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. PLEASE CONTACT SAFEGUARD AT (800) 880-1800 TO OBTAIN A COPY.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a member is pronounced

brain dead and identified as a potential organ donor. An organ procurement group will become involved to coordinate the activities.

Public Policy Committee

SafeGuard encourages members to participate in setting its public policy through its public policy committee. The purpose of this committee is to assure the comfort, dignity and convenience of our members as well as to discuss quality improvement activities and policies. If you have any questions or would like to be considered for membership on the committee, please contact SafeGuard at 800-880-1800.

Language Assistance

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require spoken or written language assistance or would like to inform SafeGuard of your preferred language, please contact us at **(800) 880-1800**.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia verbal o escrita en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con nosotros al **(800) 880-1800**.

作為SafeGuard的會員，有權獲得免費語言服務，包括口譯和筆譯。SafeGuard收集並保存有關語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要口譯或筆譯，或希望將您選擇的語言告訴SafeGuard，可通過電話或電子郵件與SafeGuard聯絡，電話是**(800) 880-1800**。

Definitions

These definitions apply when the following terms are used, unless otherwise defined where they are used. Not all defined terms are used in their usual meaning and some have meanings that limit their application; therefore, please refer to this Definitions section for a helpful understanding of the defined terms that are capitalized.

Arbitration

A non-court proceeding which is used to solve legal disputes. It is usually held before an attorney or judge who weighs the evidence and renders a binding decision, which has the force of law. Arbitration is an efficient alternative to a trial court proceeding for resolving legal disputes.

Calendar Year

A twelve (12) month period beginning on January 1 and ending on December 31 of that same year.

Close Relative

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

Company

SafeGuard Dental & Vision. Dental benefits are provided by SafeGuard Health Plans, Inc.

Contracted (Preferred or In-Network) Vision Provider

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

Co-payment

The amount listed on the Schedule of Benefits for covered services that the member is required to pay at the time of treatment.

Covered Person

You or your dependent(s) who is/are covered 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. With respect to Contracted Vision Providers, Covered Vision Charges means the Negotiated Rate. With respect to Non-Participating Vision Providers, charges in excess of SafeGuard's Maximum Benefit Allowance will not be considered Covered Charges under the plan.

Dental Records

A single complete record kept at the site of your dental care. Dental records refer to diagnostic aids, intra-oral and extra-oral radiographs, written treatment records including, but not limited to, progress notes, dental or periodontal chartings, treatment plans, consultation reports or other written material relating to an individual's medical or dental history, diagnosis, condition, treatment and/or evaluation.

Dependent

Eligible family member of a subscriber who is enrolled in SafeGuard. (See Dependent Coverage).

Emergency Services

Dental or vision services rendered for the relief of acute pain, bleeding, infection, fever, or for conditions that may result in disability or death, and where delay of treatment would be medically inadvisable.

Maximum Benefit Allowance

The maximum amount SafeGuard will reimburse for a covered visual examination provided by an out-of-network Vision Care Provider.

Medically Necessary

Covered services that are necessary and meet with professionally recognized standards of practice. The fact that a provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a covered service and material even though it is not listed in this Policy or the Schedule of Benefits as an exclusion.

With respect to a prophylaxis or fluoride treatment, those required by patients who are under MEDICAL supervision and whose medical condition precipitates gingivitis or other conditions which may require additional prophylaxis or fluoride treatment.

Member

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

Plan

Coverage for specified dental and vision care services purchased by you, or an Organization for its members, for a fixed, periodic payment made in advance of treatment. Such plans often include the use of fixed co-payments to clarify the financial obligation of covered dental and vision care, and are subject to Exclusions and Limitations.

Prepayment Fee

The monthly or annual fee paid to SafeGuard by you. The Prepayment fee (also known as “premium payment”) is not the same as a co-payment.

Selected General Dentist/Selected General Dental Office

A SafeGuard contracting dentist who agrees in writing to provide dental care services under special terms, conditions and financial reimbursement arrangements with SafeGuard.

Service Area

The Service Area is the geographical area in which SafeGuard has a panel of Selected General Dentists and Specialists who have agreed to provide care to SafeGuard members.

Termination of Benefits

A member's loss of program eligibility and disenrollment from the Plan. Reason(s) for termination of benefits are detailed within this document.

Usual Fee

The fee usually charged by the Provider to his or her private patients for a given service or material.

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 Records

A single complete record kept at the site of your vision care provider.

Vision Service Interval

A period of consecutive months, as shown in the Schedule 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.

Managed care benefits provided by SafeGuard Health Plans, Inc.

SafeGuard® and SafeGuard Dental & Vision® are registered trademarks of SafeGuard Health Enterprises, Inc.

**SafeGuard®****Individual & Family Enrollment Application - California**

Agent #: 18930

Last Name		First Name		M.I.	Social Security Number	
Home Address			City (Complete Name)		State	Zip Code
Gender ☐ Male ☐ Female	Date of Birth	Month	Day	Year	Day Time Phone ()	Email Address
Primary Language				Please note any communication impairment		
Must be completed to enroll in plan:				Facility Number 1st Choice		Facility Number 2nd Choice

Dependent Information (attach a separate sheet for additional dependents)

Circle One	Circle One	Last Name	First Name	MI	Date of Birth Mo/Day/Yr	Disability Y/N	Facility Number 1st Choice	Facility Number 2nd Choice
Spouse	Male					Yes		
Child	Female					No		
Spouse	Male					Yes		
Child	Female					No		
Spouse	Male					Yes		
Child	Female					No		
Spouse	Male					Yes		
Child	Female					No		

Select Your Payment Method – check one: ☐ Annual Check ☐ Annual Credit Card ☐ Monthly Credit Card Draft ☐ Monthly Bank Draft

Classic Choice			Premier Choice		
I am enrolling (check one)	Annual	Monthly	I am enrolling (check one)	Annual	Monthly
Myself alone	☐ \$ 94.44	☐ \$ 8.00	Myself alone	☐ \$141.60	☐ \$ 11.99
Myself & one dependent	☐ \$186.00	☐ \$ 15.75	Myself & one dependent	☐ \$265.68	☐ \$ 22.50
Myself & my family	☐ \$271.68	☐ \$ 23.00	Myself & my family	☐ \$389.76	☐ \$ 33.00
Add the application fee (*non-refundable/1-time fee)	\$ 20.00*	\$ 20.00*	Add the application fee (*non-refundable/1-time fee)	\$ 20.00*	\$ 20.00*
TOTAL AMOUNT DUE:	\$	\$	TOTAL AMOUNT DUE:	\$	\$
Credit Card Information Please charge my (check one) ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Credit Card No: _____ Expiration date: _____			Banking Information – Please debit my (check one) ☐ Checking account (include a voided check) ☐ Savings account (include a voided deposit slip) I hereby authorize SafeGuard to debit the designated prepayment fee each month from the bank account indicated above. I understand that the amount of my monthly prepayment fee will be deducted from my account and that there will be a \$15 service charge for any returned drafts.		
Authorization/ Signature: _____ Date: _____			Authorization/ Signature: _____ Date: _____		

Use and Disclosure of Personal Health Information:

Agreement - I understand that any dispute or controversy which may arise 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/vision records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental/vision records which pertain to me or any member of my family, maintained by my chosen selected provider and/or specialist, to SafeGuard and/or any designated agent or representative for the purposes of dental/vision 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.

Mail to: SafeGuard Health Plans, Inc.
Individual Billing
PO Box 8095
Laguna Hills, CA 92655-8095

I understand that the initial term of the Contract is for one year.

Signature: _____	Date: _____
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EFFECTIVE DATES OF COVERAGE

The date your SafeGuard dental & vision coverage becomes effective is based on when we receive your application and payment. If you have questions after reviewing the following, please contact us at 800.936.0324.

ANNUALLY BY CHECK OR CREDIT CARD: If your application and payment is received by the 20th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 20, your benefits will be effective April 1. After the 20th of March your benefits will be effective May 1.)

MONTHLY BANK DRAFT: If your application and payment is received by the 10th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 10, your benefits will be effective April 1. After the 10th of March, your benefits will be effective May 1.)

MONTHLY CREDIT CARD DRAFT: If your application and payment is received by the 20th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 20, your benefits will be effective April 1. After the 20th of March, your benefits will be effective May 1.)