



SUMMARY OF BENEFITS

PPO DENTAL PLAN

CENTURY D5-I10

Benefits Description	Plan Coverage (In Network)	Plan Coverage (Out-of-Network)
Calendar Year Maximum	\$1,000	\$1,000
Calendar Year Deductible	\$ 0 per person \$ 0 per family	\$ 50 per person \$150 per family
Type 1: Preventive Services Exams, X-rays, Diagnostic Tests, Prophylaxis, Fluoride, Sealants, Space Maintainers, Palliative Care	100% no deductible	80% after deductible
Type 2: Basic Services Fillings, Endodontics, Periodontics, Oral Surgery	80% no deductible	80% after deductible
Type 3: Major Services* Prosthetic Repairs, Crowns, Inlays/Onlays, Bridges, Dentures	50% no deductible	50% after deductible
Orthodontic Benefits* - Child Only Orthodontic benefits are paid at 50% of UCR (Usual, Customary, and Reasonable charges as defined in the Certificate) after the orthodontic deductible has been met. Orthodontic benefits may be applied to services rendered by any orthodontic office.	\$500 Annual Maximum \$1,000 Lifetime Maximum \$50 Deductible	
*A 12-month waiting period for Major services and Orthodontic Benefits may apply to all employees and dependents who enroll after the employer group's initial effective date.		

As a member of our PPO dental plan, you may receive care from either an in-network contracted dentist or an out-of-network dentist. If you use a contracted dentist, your out of pocket costs will be less as they provide services to our members based upon a negotiated fee schedule. You will be responsible for payment of your deductible (if any) and the co-insurance as defined by your plan.

If you receive care from a non-contracted dentist, you are responsible for your deductible (if any) and the coinsurance, plus any amount charged by the dentist that is in excess of SafeGuard's usual and customary fee.

Please refer to our Preferred Provider Directory for a listing of dentists in your area.

The benefits of this PPO plan are outlined above. Please see attached for General Exclusions and Limitations. The Policy/Certificate discloses the exact terms and conditions of coverage.

Underwritten by SafeHealth Life Insurance Company

Exclusions and Limitations

General Exclusions

The Company will not pay expenses incurred for any of the following:

1. Treatment which: a) is not listed in the Summary of Benefits or defined in the Master Policy; b) is not Medically Necessary; or, c) is experimental in nature.
2. Inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
4. Orthodontic services, supplies, or oral surgery procedures for the purposes of orthodontic treatment, inclusive of extractions unless orthodontics are a covered benefit under this plan or any applicable rider.
5. Services and supplies provided primarily for cosmetic purposes.
6. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.
7. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least three years.
8. Athletic mouthguards, denture duplication; infection control; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
9. Implants, related procedures or services involving tooth implantation.
10. Grafting (bone or tissue) and guided tissue regeneration.
11. Biopsy, the removal or treatment of cysts, tumors or neoplasms and any lab reports related to such services.
12. Treatment involving or relating to congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth.
13. Therapeutic drug injections.
14. Dispensing of drugs not normally supplied in a dental office.
15. Maryland bridges.
16. Over dentures and associated procedures.
17. Services or supplies provided by a Dentist, Dental Hygienist, Denturist or Doctor who is: a) a close relative or a person who ordinarily resides with the Covered Person; b) an Employee of the Employer; c) the Employer.
18. Services rendered through a clinic or similar facility or unit provided or maintained by the Employer (or the Employer of your spouse, if different).
19. Hospital or facility charges for room, supplies or emergency room expenses; or routine chest x-rays and medical exams prior to oral surgery.
20. Services or supplies received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
21. Services and supplies obtained while outside the United States, except for Emergency Dental Care.
22. Replacement of a lost or stolen appliance or prosthesis.
23. Any expenses compensable under any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law, or agency, except Medicare or Medicaid.
24. Care rendered within any facility of, or provided by: 1) the United States Government or any agency thereof; 2) any hospital or institution which does not require the Covered Person to pay for such services in the absence of insurance.
25. Services, procedures, or supplies for which a charge would not have been made in the absence of insurance.

Exclusions and Limitations

26. Procedures, services or supplies for which the Covered Person does not have to pay, except when payment of such benefits is required by law and then only to the extent required by law.
27. Any procedure or appliance started before the effective date or after the termination date of the Covered Person's insurance.
28. Replacement of teeth missing on Covered Person's effective date of coverage for the purpose of the initial placement of a full denture, partial denture or fixed bridge.

Limitations - Preventive Services

1. Initial or periodic oral exams are limited to 1 per 6-month period. Initial exams will be limited to the allowance for a periodic exam except for the initial (first) exam on a new patient.
2. X-rays are limited as follows:
 - a. Intraoral
 - i. Intraoral complete series x-rays, including four (4) bite-wings and up to 14 periapical x-rays, or panoramic film with four (4) bite-wings, either are limited to one (1) per 36-month period and no payment for any combination of films shall exceed the amount determined for a complete series of x-rays.
 - ii. Intraoral periapical x-rays are limited to four (4) films per six (6) month period when performed as a separate procedure from a complete series of x-rays.
 - iii. Intraoral occlusal x-rays are limited to two (2) films per 12-month period.
 - b. Bite-wings
 - i. Bite-wing x-rays series (two or four films) are limited to one (1) per 12-month period.
 - ii. Bite-wing x-rays are not covered within a 12-month period from the date of an intraoral complete series x-rays.
 - c. Panoramic film without bite-wings are limited to one (1) per 36-month period if an intraoral complete or panoramic x-ray with bite-wings has not been provided in a 36-month period.
 - d. Extraoral x-rays are limited to two (2) films per 12-month period.
3. Dental prophylaxis (cleaning and scaling) is limited to 1 per 6-month period.
4. Topical fluoride treatment is limited to one (1) per 12-month period for Dependent children under age 16.
5. Sealants are limited to one (1) application to an unrestored permanent molar tooth per 36-month period for Dependent children under age 14.
6. Space maintainers for primary teeth, including all adjustments and recementation made within six (6) months of installation, are limited to Dependent children under age 14.

Limitations – Basic Services

1. Root canal therapy (including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care) is limited to one (1) time on the same tooth.
2. Root canal re-treatment (including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care performed more than 12 months after the initial therapy) is limited to 1 time on the same tooth per 12-month period.
3. Hemisection, including any root removal and local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.
4. Periodontal scaling and root planing (per quadrant) is limited to 1 time per quadrant per 12-month period and only if not performed on the same date of service as a prophylaxis or any other periodontal procedure.
5. Periodontal Maintenance Procedure/prophylaxis (including minor scaling) is allowed 1 per 6 months following scaling and root planing.

Exclusions and Limitations

6. Periodontal surgery related services are limited to: (a) 1 time per quadrant of the mouth in any 36-month period with charges combined for gingivectomy, gingival curettage, mucogingival or osseous surgery performed in the same quadrant within the same 36-month period; and (b) crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, limited to one time per tooth per lifetime.
7. Periodontal splinting guards following active periodontal treatment is limited to 1 appliance per 24-month period.
8. General anesthesia and intravenous sedation is covered only in conjunction with the extraction of impacted teeth and considered for payment as a separate benefit only when Medically Necessary.
9. Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least: (a) 12 months have passed since the existing amalgam restoration was placed; or (b) acid etch is not covered as a separate procedure.
10. Benefits for the replacement of an existing composite restoration will only be considered for payment if at least 12 months have passed since the existing composite restoration was placed.
11. Benefits for composite resin restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
12. Pin retained restorations, covered only in conjunction with an amalgam or composite restoration, are limited to one (1) time per tooth.
13. Stainless steel crowns are limited to one (1) per tooth per 36-month period for teeth not restorable by an amalgam or composite filling for Dependent children to age 19.

Limitations - Major Services

1. Inlays and onlays are (i) covered only if more than five (5) years have elapsed since last placement; (ii) limited to persons age 19 and above; and (iii) composite or porcelain are not covered on molar teeth.
2. Porcelain or porcelain fused to metal crowns are not covered on molar teeth.
3. Crowns are (i) covered only if more than five (5) years have elapsed since last placement; and (ii) are limited to persons over age 16.
4. Full dentures are limited to one (1) time per arch unless five (5) years have elapsed since last placement and the denture cannot be made serviceable.
5. Partial dentures, including any clasps and rests and all teeth, are limited to one (1) partial denture per arch unless five (5) years have elapsed since last placement and the partial denture cannot be made serviceable.
6. Full or partial dentures (adjustments) are limited to one (1) time per arch in any 12-month period following the initial six (6) month denture placement period.
7. Relining or rebasing dentures are limited to one (1) time per arch per 36-month period; and when done within 12 months of the insertion of the denture.
8. Tissue conditioning (limited to services performed more than 12 months after the initial insertion of the denture) is limited to two (2) treatments per arch every 12 months.
9. Fixed bridges are limited to persons over the age of 16;
 - (i) benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than five (5) years old and cannot be made serviceable;
 - (ii) a fixed bridge is the benefit for the replacement of a missing single tooth within the same arch only;
 - (iii) a removable partial denture is the benefit for the replacement of more than one (1) missing tooth in the same arch, limited to one (1) per five (5) years;
 - (iv) a fixed bridge replacing the extracted portion of a hemisected tooth is not covered.
10. Recementing inlays, onlays, crowns and bridges are limited to services performed more than 12 months after the initial insertion and limited to one (1) service in any 12 consecutive month period.

Orthodontic Exclusions and Limitations

1. Benefit is limited to Dependent children under the age of 19.
2. Benefits for orthodontic treatment program are payable only if the treatment begins after a Covered Person's effective date of coverage.
3. Cephalometric x-ray is limited to once in any two-year period.
4. Diagnostic casts (study models) are limited to one per Covered Person.
5. Harmful habit appliance is limited to Dependent children under age 16, once per lifetime.
6. (a) Orthognatic surgical procedures or oral surgery procedures for the purposes of orthodontic treatment, inclusive of extractions, (b) temporomandibular joint disorders (T.M.J.), and (c) handicapping malocclusion are excluded.