

**DENTAL CARE BENEFITS
SCHEDULE OF COVERED DENTAL SERVICES**

DIAGNOSTIC AND PREVENTIVE SERVICES	7/1/10 MAXIMUM AMOUNTS
Oral Examinations	
(Limited to twice during any calendar year)	
Comprehensive exam.....	\$ 48.00
Periodic exam.....	37.00
X-Rays	
Intraoral, full mouth series, including bitewings.....	83.00
(Limited to once during any period of 36 consecutive months)	
Intraoral, single first film.....	14.00
Intraoral, each additional film.....	10.00
Bitewings, two films (Limited to twice during any calendar year).....	28.00
Bitewings, four films (Limited to twice during any calendar year).....	42.00
Prophylaxis	
(Limited to twice during any calendar year)	
Prophylaxis for persons age 14 or over.....	70.00
Prophylaxis for children under age 14.....	42.00
Fluoride Treatment	
(Limited to children under age 19)	
Topical application of fluoride.....	26.00
(Limited to once during any calendar year)	
Space Maintainers	
(Includes adjustments within 6 months after installation)	
Fixed, unilateral type(Limited to children under age 16).....	126.00
Sealants -	
Limited to permanent molar teeth once in each 36 month period.....	29.00
GENERAL SERVICES	
Limited Oral Evaluation-problem focused 2 per calendar year	37.00
*Emergency palliative treatment.....	79.00
Consultation by other than dentist providing treatment.....	109.00
General Anesthesia in conjunction with surgical procedures by report only.	
*When no other service performed on same day.	

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(continued)**

BASIC SERVICES	7/1/10 MAXIMUM AMOUNTS
Amalgam Restorations	
One surface, permanent.....	87.00
Two surface, permanent.....	110.00
Three surface, permanent or more	134.00
Pin retention, exclusive of amalgam	27.00
Plastic or Composite Restorations	
Composite, resin, one surface	107.00
Composite, resin, two surfaces	134.00
Composite resin, three or more	165.00
Other Restorative	
Re-cement inlays	52.00
Re-cement crowns	50.00
ENDODONTIC SERVICES	
Pulp Capping	
Pulp cap, direct (excluding final restoration).....	57.00
Pulpotomy-Limited to primary teeth	
Vital pulpotomy (excluding final restoration)	108.00
Root Canal Therapy - Includes X-rays and follow-up care	
Anterior (excluding final restoration)	586.00
Bicuspid (excluding final restoration).....	715.00
Molar (excluding final restoration)	924.00
PERIODONTIC SERVICES	
(If more than one periodontal surgical service is performed per quadrant only, the one with the largest Maximum Covered Expense is a Dental Service.)	
Gingivectomy or gingivoplasty, per quadrant.....	383.00
Gingivectomy or gingivoplasty, 1-3 contiguous teeth	183.00
(Limited to four quadrants per calendar year)	
Osseous surgery, including gingival flap entry and closing, per quadrant	727.00
Periodontal Maintenance.....	144.00
Periodontal scaling/root planning per quadrant (Limited to four quadrants per calendar year)	183.00

**DENTAL CARE BENEFITS
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(continued)**

7/1/10

ORAL SURGERY

**MAXIMUM
AMOUNTS**

Extractions

(Includes anesthetics and routine post-operative care)

Extraction, Coronal remnants.....	100.00
Removal of erupted tooth.....	198.00
Removal of impacted tooth, partially bony.....	331.00
Removal of impacted tooth, completely bony.....	359.00

MAJOR RESTORATIVE SERVICES

Restorative Cast Restorations and crowns are covered only when necessitated by decay or traumatic injury and the tooth cannot be restored with a routine filling material. All major services are subject to 5 year replacement limit.

Inlay Restorations

One surface.....	511.00
Two surfaces.....	539.00
Three surfaces.....	576.00

Crowns - Single Restorations/and Abutment Crowns

Porcelain jacket.....	596.00
Porcelain with Hi Noble metal.....	676.00
Porcelain with semi-precious metal.....	618.00
Full cast Hi Nobel.....	626.00
Stainless steel.....	190.00
Post and core.....	216.00

Pontics

Cast Gold.....	661.00
Porcelain fused to metal.....	599.00

PROSTHODONTIC SERVICES

DENTURES AND PARTIAL DENTURES covered charge for dentures and partial dentures including adjustments and relines within six months after installation. Specialized techniques and characterizations are not covered.

Complete Dentures

(Includes post-delivery care)

Complete Upper.....	776.00
Complete Lower.....	776.00

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(continued)**

Partial Dentures	7/1/10 MAXIMUM AMOUNTS
<i>(Includes post-delivery care)</i>	
Partial upper or lower with two clasps with rests, acrylic base.....	733.00
Partial upper or lower with bar and two clasps, acrylic base.....	852.00
Partial upper or lower with bar and two clasps, cast base.....	784.00
Repairs to Dentures	
Add tooth to partial denture to replace extracted tooth, not involving clasp.....	158.00
Add tooth to partial denture to replace extracted tooth, involving class.....	158.00
Denture Relining or Rebasing	
<i>More than six months after installation (Limited to one per denture during any period of 36 consecutive months)</i>	
Denture reline, upper or lower, partial or complete, office.....	162.00
Denture reline, upper or lower, partial or complete, laboratory.....	211.00

**THE ABOVE SCHEDULED BENEFITS REPRESENT COMMONLY
USED PROCEDURES.**