Scheduled Benefit Plan - Region IV BRONZE COVERAGE SCHEDULE

We will pay the benefit amount shown for dental procedures and services listed in this schedule, not to exceed the provider's actual charges.

I. Diagnostic & Preventive		
00120	Periodic Oral Evaluation	$28
00140	Limited Oral Evaluation-Problem Focused	$43
00150	Comprehensive Oral Evaluation	$43
00160	Detailed Exten Oral Eval-Problem Focused	$43
00180	Comp Perio Evaluation	$43
00210	Intraoral-Complete Series including Bitewings	$82
00220	Intraoral-Periapical-First Film	$16
00230	Intraoral-Periapical-Each Additional Film	$12
00240	Intraoral-Occlusal Film	$23
00270	Bitewings-Single Film	$17
00272	Bitewings-Two Films	$26
00274	Bitewings-Four Films	$38
00277	Vertical Bitewings-7 To 8 Films	$50
00330	Panoramic Film	$72
01110	Prophylaxis-Adult	$58
01120	Prophylaxis-Child	$41
01201	Topical Applic Of Fluoride Incld/Pxs Child	$55
01203	Topical Applic Fluoride Pxs Not Incl-Child	$22
01351	Sealant-Per Tooth	$32

II. Minor Restorative		
01510	Space Maintainer-Fixed-Unilateral	$102
01515	Space Maintainer-Fixed-Bilateral	$134
01520	Space Maintainer-Removable-Unilateral	$126
01525	Space Maintainer-Removable-Bilateral	$172
01550	Recementation Of Space Maintainer	$22
02140	Amalgam-One Surface	$61
02150	Amalgam-Two Surfaces	$74
02160	Amalgam-Three Surfaces	$90
02161	Amalgam-Four Or More Surfaces	$111
02330	Resin-1 Surface, Anterior	$70
02331	Resin-2 Surfaces, Anterior	$88
02332	Resin-3 Surfaces, Anterior	$106
02335	Resin-4+Surf Or Invl Incisal Angle(Anterior)	$126
02390	Resin Comp Crwn, Ant	$150
02391	Resin Comp - 1 Surf Posterior	$78
02392	Resin Comp - 2 Surf Posterior	$106
02393	Resin Comp - 3 Surf Posterior	$132

II. Minor Restorative (continued)		
02394	Resin Comp - 4+ Surf Posterior	$158
02910	Recement Inlay	$46
02920	Recement Crown	$48
02930	Prefab Stainless Steel Crown-Primary	$82
02931	Prefab Stainless Steel Crown-Permanent	$93
02932	Prefab Resin Crown	$101
02933	Prefab Stainless Steel Crown W/Resin Window	$113
02940	Sedative Filling	$50
06930	Recement Fixed Partial Denture	$43

III. Routine Extractions		
07111	Coronal Remnants-Deciduous Tooth	$70
07140	Extrct, Erupt Tth Or Exposed Root	$70

Deductible Amount for Eligible Expenses	
Each Covered Individual Per Calendar Year	$50
Each Covered Family Unit Per Calendar Year	$150
(Deductible not applicable to Class I)	

Limitations

Exams (00120, 00150, 00160, 00180) - 2 per calendar year
Intraoral Radiographs/Complete Series (00210 -1 every 36 mo.
Panoramic Film (00330) - 1 every 36 months
Bitewings (00270, 00272, 00274, 00277) - 2 per calendar year
Cleanings (01110, 01120, 01201) - 2 per calendar year
Fluoride (01203) - 1 per calendar year; up to age 19
Sealants (01351) - 1st & 2nd molars; up to age 19

Probationary Period	
Eligible Expenses in Class I, II, III	None

Maximum Benefit Amount	
Each Calendar Year	$1000

Policy provisions vary by state. Dental Insurance is not available in all states. The policy has exclusions, limitations and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. Please contact your Marketing Representative for availability in your state.

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