

IMPORTANT INFORMATION ABOUT YOUR PLAN

- This Schedule of Benefits provides a listing of procedures covered by Your Plan. For procedures that require a Copayment, the amount to be paid is shown in the column titled "Member Pays \$." You pay these Copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive Covered Services. Your PDO will perform the below procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Evidence of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- In-Network Dentists will charge an additional \$125 for the use of precious (high noble) or semi precious (noble) metal.
- For a complete description of Your Plan, please refer to the Evidence of Coverage and the Exclusions and Limitations in addition to this Schedule of Benefits.
- If You have any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at **1-866-357-3304** or access Our Website at **www.unitedconcordia.com**.

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
CLINICAL ORAL EVALUATIONS			OTHER PREVENTIVE SERVICES		
D0120	Periodic oral evaluation - established patient	0	D1330	Oral hygiene instructions	0
D0140	Limited oral evaluation - problem focused	0	D1351	Sealant - per tooth	0
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	0	SPACE MAINTENANCE (passive appliances)		
D0150	Comprehensive oral evaluation - new or established patient	0	D1510	Space maintainer - fixed - unilateral	21
D0160	Detailed and extensive oral evaluation - problem focused, by report	0	D1515	Space maintainer - fixed - bilateral	32
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0	D1520	Space maintainer - removable - unilateral	40
D0180	Comprehensive periodontal evaluation - new or established patient	0	D1525	Space maintainer - removable - bilateral	45
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)			D1550	Re-cementation of space maintainer	0
D0210	Intraoral - complete series (including bitewings)	0	D1555	Removal of fixed space maintainer	8
D0220	Intraoral - periapical first film	0	AMALGAM RESTORATIONS (including polishing)		
D0230	Intraoral - periapical each additional film	0	D2140	Amalgam - one surface, primary or permanent	0
D0240	Intraoral - occlusal film	0	D2150	Amalgam - two surfaces, primary or permanent	0
D0270	Bitewing - single film	0	D2160	Amalgam - three surfaces, primary or permanent	0
D0272	Bitewings - two films	0	D2161	Amalgam - four or more surfaces, primary or permanent	0
D0273	Bitewings - three films	0	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D0274	Bitewings - four films	0	D2330	Resin-based composite - one surface, anterior	0
D0277	Vertical bitewings - 7 to 8 films	0	D2331	Resin-based composite - two surfaces, anterior	0
D0330	Panoramic film	0	D2332	Resin-based composite - three surfaces, anterior	0
D0340	Cephalometric film	0	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	0
TESTS AND EXAMINATIONS			D2390	Resin-based composite crown, anterior	0
D0460	Pulp vitality tests	0	D2391	Resin-based composite - one surface, posterior	85
D0470	Diagnostic casts	0	D2392	Resin-based composite - two surfaces, posterior	109
DENTAL PROPHYLAXIS			D2393	Resin-based composite - three surfaces, posterior	133
D1110	Prophylaxis - adult	0	D2394	Resin-based composite - four or more surfaces, posterior	140
D1120	Prophylaxis - child	0	INLAY/ONLAY RESTORATIONS		
TOPICAL FLUORIDE TREATMENT (office procedure)			D2510	Inlay - metallic - one surface	62 ♦
D1203	Topical application of fluoride (prophylaxis not included) - child	0			
D1204	Topical application of fluoride (prophylaxis not included) - adult	0			
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	0			

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
D2520	Inlay - metallic - two surfaces	70 ♦			
D2530	Inlay - metallic - three or more surfaces	70 ♦			
D2542	Onlay - metallic - two surfaces	80 ♦			
D2543	Onlay - metallic - three surfaces	80 ♦			
D2544	Onlay - metallic - four or more surfaces	85 ♦			
CROWNS - SINGLE RESTORATIONS ONLY			ENDODONTIC THERAPY ON PRIMARY TEETH		
D2710	Crown - resin-based composite (indirect)	50	D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	10
D2712	Crown - 3/4 resin-based composite (indirect)	50	D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	12
D2740	Crown - porcelain/ceramic substrate	130	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)		
D2750	Crown - porcelain fused to high noble metal	110 ♦	D3310	Anterior (excluding final restoration)	40
D2751	Crown - porcelain fused to predominantly base metal	110	D3320	Bicuspid (excluding final restoration)	60
D2752	Crown - porcelain fused to noble metal	110 ♦	D3330	Molar (excluding final restoration)	95
D2780	Crown - 3/4 cast high noble metal	110 ♦	ENDODONTIC RETREATMENT		
D2781	Crown - 3/4 cast predominantly base metal	110	D3346	Retreatment of previous root canal therapy - anterior	55
D2782	Crown - 3/4 cast noble metal	110 ♦	D3347	Retreatment of previous root canal therapy - bicuspid	58
D2783	Crown - 3/4 porcelain/ceramic	130	D3348	Retreatment of previous root canal therapy - molar	75
D2790	Crown - full cast high noble metal	110 ♦	APICOECTOMY/PERIRADICULAR SERVICES		
D2791	Crown - full cast predominantly base metal	110	D3410	Apicoectomy/periradicular surgery - anterior	55
D2792	Crown - full cast noble metal	110 ♦	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	55
D2794	Crown - titanium	110	D3425	Apicoectomy/periradicular surgery - molar (first root)	55
D2799	Provisional crown	0	D3426	Apicoectomy/periradicular surgery (each additional root)	20
OTHER RESTORATIVE SERVICES			D3430	Retrograde filling - per root	0
D2910	Recement inlay, onlay, or partial coverage restoration	0	D3450	Root amputation - per root	0
D2915	Recement cast or prefabricated post and core	5	OTHER ENDODONTIC PROCEDURES		
D2920	Recement crown	5	D3910	Surgical procedure for isolation of tooth with rubber dam	0
D2930	Prefabricated stainless steel crown - primary tooth	20	D3920	Hemisection (including any root removal), not including root canal therapy	25
D2931	Prefabricated stainless steel crown - permanent tooth	25	D3950	Canal preparation and fitting of preformed dowel or post	0
D2932	Prefabricated resin crown	30	SURGICAL SERVICES (including usual postoperative care)		
D2933	Prefabricated stainless steel crown with resin window	30	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	20
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	30	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	10
D2940	Sedative filling	0	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	35
D2950	Core buildup, involving and including any pins	15	D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	14
D2951	Pin retention - per tooth, in addition to restoration	0	D4245	Apically positioned flap	40
D2952	Post and core in addition to crown, indirectly fabricated	22	D4249	Clinical crown lengthening - hard tissue	50
D2953	Each additional indirectly fabricated post - same tooth	10	D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	50
D2954	Prefabricated post and core in addition to crown	19	D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	20
D2955	Post removal (not in conjunction with endodontic therapy)	0	D4263	Bone replacement graft - first site in quadrant	120
D2957	Each additional prefabricated post - same tooth	10	D4264	Bone replacement graft - each additional site in quadrant	92
D2970	Temporary crown (fractured tooth)	28			
D2971	Additional procedures to construct new crown under existing partial denture framework	25			
D2980	Crown repair, by report	0			
PULP CAPPING					
D3110	Pulp cap - direct (excluding final restoration)	0			
D3120	Pulp cap - indirect (excluding final restoration)	0			
PULPOTOMY					
D3220	Therapeutic pulpotomy (excluding final restoration)	9			
D3221	Pulpal debridement, primary and permanent teeth	9			

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D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	33	D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	82
NON-SURGICAL PERIODONTAL SERVICES			DENTURE REBASE PROCEDURES		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	15	D5710	Rebase complete maxillary denture	7
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	4	D5711	Rebase complete mandibular denture	7
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0	D5720	Rebase maxillary partial denture	5
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	43	D5721	Rebase mandibular partial denture	5
OTHER PERIODONTAL SERVICES			DENTURE RELINE PROCEDURES		
D4910	Periodontal maintenance	20	D5730	Reline complete maxillary denture (chairside)	10
COMPLETE DENTURES (including routine post-delivery care)			D5731	Reline complete mandibular denture (chairside)	10
D5110	Complete denture - maxillary	150	D5740	Reline maxillary partial denture (chairside)	10
D5120	Complete denture - mandibular	150	D5741	Reline mandibular partial denture (chairside)	10
D5130	Immediate denture - maxillary	165	D5750	Reline complete maxillary denture (laboratory)	25
D5140	Immediate denture - mandibular	165	D5751	Reline complete mandibular denture (laboratory)	25
PARTIAL DENTURES (including routine post-delivery care)			D5760	Reline maxillary partial denture (laboratory)	25
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	90	D5761	Reline mandibular partial denture (laboratory)	25
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	90	OTHER REMOVABLE PROSTHETIC SERVICES		
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	125	D5850	Tissue conditioning, maxillary	5
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	125	D5851	Tissue conditioning, mandibular	5
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	144	FIXED PARTIAL DENTURE PONTICS		
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	144	D6205	Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	130
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	100	D6210	Pontic - cast high noble metal	100 ♦
ADJUSTMENTS TO DENTURES			D6211	Pontic - cast predominantly base metal	100
D5410	Adjust complete denture - maxillary	5	D6212	Pontic - cast noble metal	100 ♦
D5411	Adjust complete denture - mandibular	5	D6214	Pontic - titanium	100
D5421	Adjust partial denture - maxillary	5	D6240	Pontic - porcelain fused to high noble metal	100 ♦
D5422	Adjust partial denture - mandibular	5	D6241	Pontic - porcelain fused to predominantly base metal	100
REPAIRS TO COMPLETE DENTURES			D6242	Pontic - porcelain fused to noble metal	100 ♦
D5510	Repair broken complete denture base	10	D6245	Pontic - porcelain/ceramic	130
D5520	Replace missing or broken teeth - complete denture (each tooth)	10	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
REPAIRS TO PARTIAL DENTURES			D6545	Retainer - cast metal for resin bonded fixed prosthesis	90
D5610	Repair resin denture base	10	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D5620	Repair cast framework	10	D6710	Crown - indirect resin based composite	130
D5630	Repair or replace broken clasp	10	D6740	Crown - porcelain/ceramic	130
D5640	Replace broken teeth - per tooth	10	D6750	Crown - porcelain fused to high noble metal	110 ♦
D5650	Add tooth to existing partial denture	10	D6751	Crown - porcelain fused to predominantly base metal	100
D5660	Add clasp to existing partial denture	10	D6752	Crown - porcelain fused to noble metal	100 ♦
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	82	D6780	Crown - 3/4 cast high noble metal	100 ♦
			D6781	Crown - 3/4 cast predominantly base metal	100
			D6782	Crown - 3/4 cast noble metal	100 ♦
			D6783	Crown - 3/4 porcelain/ceramic	130
			D6790	Crown - full cast high noble metal	100 ♦
			D6791	Crown - full cast predominantly base metal	100
			D6792	Crown - full cast noble metal	100 ♦
			D6794	Crown - titanium	100
			OTHER FIXED PARTIAL DENTURE SERVICES		
			D6930	Recement fixed partial denture	0
			D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	22
			D6972	Prefabricated post and core in addition to fixed partial denture retainer	19
			D6973	Core build up for retainer, including any pins	15
			D6976	Each additional indirectly fabricated post - same tooth	10

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D6977	Each additional prefabricated post - same tooth	10			
D6980	Fixed partial denture repair, by report	0			
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)					
D7111	Coronal remnants - deciduous tooth	0			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0			
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)					
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	15			
D7220	Removal of impacted tooth - soft tissue	20			
D7230	Removal of impacted tooth - partially bony	25			
D7240	Removal of impacted tooth - completely bony	30			
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	40			
D7250	Surgical removal of residual tooth roots (cutting procedure)	10			
OTHER SURGICAL PROCEDURES					
D7280	Surgical access of an unerupted tooth	16			
D7283	Placement of device to facilitate eruption of impacted tooth	4			
D7285	Biopsy of oral tissue - hard (bone, tooth)	25			
D7286	Biopsy of oral tissue - soft (all others)	25			
D7288	Brush biopsy - transepithelial sample collection	45			
ALVEOLOPLASTY (surgical preparation of ridge for dentures)					
D7310	Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0			
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	15			
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	9			
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS					
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	40			
SURGICAL INCISION					
D7510	Incision and drainage of abscess - intraoral soft tissue	15			
D7520	Incision and drainage of abscess - extraoral soft tissue	25			
OTHER REPAIR PROCEDURES					
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	20			
D7963	Frenuloplasty	10			
D7970	Excision of hyperplastic tissue - per arch	30			
D7971	Excision of pericoronal gingiva	15			
COMPREHENSIVE ORTHODONTIC TREATMENT					
D8070	Comprehensive orthodontic treatment of the transitional dentition	1,500			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1,500			
D8090	Comprehensive orthodontic treatment of the adult dentition	2,000			
OTHER ORTHODONTIC SERVICES					
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	240			
†	Orthodontic records fee	265			
UNCLASSIFIED TREATMENT					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	8			
ANESTHESIA					
D9210	Local anesthesia not in conjunction with operative or surgical procedures	0			
D9211	Regional block anesthesia	0			
D9212	Trigeminal division block anesthesia	0			
D9215	Local anesthesia	0			
D9220	Deep sedation/general anesthesia - first 30 minutes	160			
D9221	Deep sedation/general anesthesia - each additional 15 minutes	68			
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	170			
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	42			
PROFESSIONAL CONSULTATION					
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist and physician	0			
PROFESSIONAL VISITS					
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0			
D9440	Office visit, after regularly scheduled hours	40			
MISCELLANEOUS SERVICES					
D9951	Occlusal adjustment - limited	5			
D9952	Occlusal adjustment - complete	25			
★	Broken appointment per 30 minutes (without 24-hour notice)	20			
FOOTNOTES					
†	Please report under code D8999 "Unspecified orthodontic procedure, by report." Records include all diagnostic procedures, such as cephalometric films, full mouth x-rays, models, and treatment plans.				
★	Please report under code D9999 "Unspecified adjunctive procedure, by report."				
◆	Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional \$125 for these materials.				

SCHEDULE OF EXCLUSIONS & LIMITATIONS

EXCLUSIONS:

Except as specifically provided in this Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members outside of the office in which the Member is enrolled and which are not pre-authorized by the Company (including specialty care services).
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.
4. That are necessary due to lack of cooperation with the treating dentist, or failure to comply with a professionally prescribed Treatment Plan.
5. Started or incurred prior to the Member's eligibility under the Company or after the Termination Date of coverage with the Company.
6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
7. That do not meet accepted standards of dental treatment, which are Experimental or Investigative in nature or are considered enhancements to standard dental treatment as determined by the Company.
8. For hospitalization and associated costs for rendering services in a hospital.
9. Determined by the Company to be the responsibility of Worker's Compensation or employer's liability or health care plan, or payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.
10. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
11. Which are principally Cosmetic in nature, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures as determined by the Company.
12. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
13. For services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.
14. That restore tooth structure lost due to attrition, erosion or abrasion.
15. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
16. For the following, which are not included as orthodontic benefits – retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of twenty-four (24) months.
17. For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants.
18. Required because of, or in connection with, acts of war, declared or undeclared.
19. For elective procedures, including, but not limited to, prophylactic extractions of third molars.

LIMITATIONS

The following services will be subject to Limitations as set forth below:

1. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
2. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's 7th birthday. However, exceptions for physical or mental handicaps or medically compromised children, when confirmed by a physician, may be considered on an individual basis with prior approval from the Company.
3. Member must remain in the Plan during the period of time they are undergoing orthodontic treatment. Any early termination can result in additional charges for all unfinished work. This limitation only applies to subscriber termination, not group termination.
4. Sealants – one (1) per tooth per three (3) year period through age ten (10) on permanent first molars and through age fifteen (15) on permanent second molars.
5. In the case a Dental Emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of \$100 for each emergency visit.
6. Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) consecutive months in combination with routine prophylaxis.
7. Periodontal scaling and root planing - one (1) per twenty-four (24) consecutive month period per area of the mouth.
8. Surgical periodontal procedures - one (1) per thirty-six (36) consecutive month period per area of the mouth.
9. Root canal retreatment – one (1) per tooth per lifetime.
10. Panoramic or full mouth x-rays - one (1) every three (3) years.
11. One (1) set of bitewing x-rays per six (6) consecutive months.
12. Prophylaxis - one (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits.
13. Fluoride treatment - one (1) per six (6) consecutive months through age eighteen (18).
14. Crown lengthening - one (1) per tooth per lifetime.
15. Denture relining or rebasing - integral if provided within six (6) months of insertion by the same dentist. This limitation does not apply to immediate dentures.
16. Subsequent denture relining or rebasing - limited to one (1) every thirty-six (36) consecutive months thereafter.
17. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

Governing Administrative Guidelines

Alternative Treatment

Occasionally, the Panel Dental Office and/or the member may consider alternative treatment plans. In those instances where the member agrees to an alternative treatment plan rather than the benefit provided by United Concordia, the cost for such treatment will be based upon the following formula:

Provider's Usual Fee of the <u>alternate</u> treatment	<i>less</i>	Provider's Usual Fee of the entitled benefit	<i>plus</i>	Member's Copayment for the entitled benefit	=	FEE CHARGED TO MEMBER
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Fixed Prosthetics (Bridges)

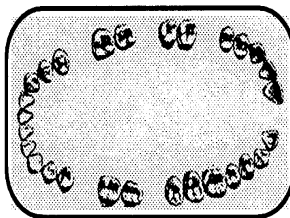
Services must be diagnosed and prescribed by the participating provider to be eligible for coverage. The member is eligible for fixed bridge restoration when:

- there is a posterior one-sided space involving one or two adjacent teeth, and front and back anchor teeth;
- the bridge will replace incisor teeth missing in the upper or lower anterior segments defined as cuspid to cuspid (#6-11 or #22-27);
- anchor teeth and occlusion are clinically healthy, resulting in a favorable prognosis.

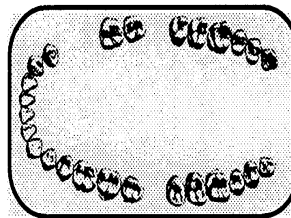
The Plan does not cover a fixed bridge when:

- there are missing teeth on both sides of the mouth in the same arch (bridges currently in place are not considered missing teeth unless unserviceable). *
- anterior (front) and posterior (back) spaces (missing teeth) are present in the same arch. In this case, a partial denture is the covered benefit.*
- replacing a serviceable partial denture or fixed bridge;
- the bridge is used to realign misaligned teeth, including diastemas (spaces between teeth);
- the member is under the age of 16 and having permanent teeth replaced;
- one or more anchor teeth is an implant.

*Note: The term "missing teeth" does not include third molars for the purpose of this guideline. In addition, missing teeth do not apply to this guideline if the resultant space is closed to less than 1/2 of the width of a bicuspid.



Bridge Ineligibility



Bridge Eligibility