

CALIFORNIA DENTAL 161/D0121 SCHEDULE OF BENEFITS



Welcome to the UnitedHealthcare SignatureValue (HMO) Dental 161 plan. This publication is a legal document called Schedule of Benefits. It provides the details of your plan, including Exclusions, along with a list of dental procedures and their corresponding Copayments (the amount you pay to your Assigned Dental Provider Group at the time of your visit).

This publication is part of your Combined Evidence of Coverage and Disclosure Form. Together, these documents explain your coverage. For additional information, please contact Customer Service at 1-800-228-3384.

The following Copayments apply ONLY when treatment is performed by your Assigned Dental Provider Group.

Code	Procedure	Copayment
I. DIAGNOSTIC		
—	Office visit.....	\$0
D0120	Periodic oral examination	\$0
D0140	Limited oral evaluation - problem focused	\$5
D0150	Comprehensive oral examination	\$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$0
D0170	Re-evaluation - limited, problem focused	\$5
D0180	Comprehensive periodontal evaluation - new or established patient	\$0
D0210	Radiographs - intraoral - complete series (bitewings included) (once in any 2-year period)	\$0
D0220	Radiographs - intraoral - periapical first film	\$0
D0230	Radiographs - intraoral - periapical each additional film	\$0
D0240	Radiographs - intraoral - occlusal film	\$0
D0250	Radiographs - extraoral - first film	NTCV
D0260	Radiographs - extraoral - each additional film	NTCV
D0270	Radiographs - bitewing - single film (4 in any 6-month period)	\$0
D0272	Radiographs - bitewings - 2 films (2 in any 6-month period)	\$0
D0274	Radiographs - bitewings - 4 films (1 in any 6-month period)	\$0
D0277	Radiographs - vertical bitewings - 7 to 8 films	NTCV
D0290	Radiographs - posterior-anterior or lateral skull and facial bone survey film	NTCV
D0310	Radiographs - sialography	NTCV
D0320	Radiographs - temporomandibular joint arthrogram, including injection	NTCV
D0321	Radiographs - other temporomandibular joint films, by report	NTCV
D0322	Radiographs - tomographic survey	NTCV
D0330	Radiographs - panoramic film	\$0
D0340	Radiographs - cephalometric film	NTCV
D0350	Radiographs - oral/facial images.....	NTCV
D0415	Test and lab exams - bacteriologic studies for determination of pathologic agents.....	NTCV
D0425	Test and lab exams - caries susceptibility tests.....	NTCV
D0460	Test and lab exams - pulp vitality tests	\$0
D0470	Test and lab exams - diagnostic casts.....	\$10
D0471	Test and lab exams - diagnostic photographs	\$0
D0472	Accession of tissue, gross exam, preparation and transmission of written report	NTCV
D0473	Accession of tissue, gross and microscopic exam, preparation and transmission of written report	NTCV
D0474	Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation and transmission of written report	NTCV
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report	NTCV

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Code	Procedure	Copayment
D0501	Histopathologic examinations.....	\$0
D0502	Other oral pathology procedures, by report.....	\$0
D0999	Unspecified diagnostic procedure, by report.....	NTCV
II. PREVENTIVE		
D1110	Prophylaxis - adult (once every 6 months).....	\$0
D1120	Prophylaxis - child (once every 6 months).....	\$0
D1201	Topical application of fluoride (including prophylaxis) - child (under age 18) (once per calendar year).....	\$0
D1203	Topical application of fluoride (excluding prophylaxis) - child (under age 18) (once per calendar year).....	\$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult (once per calendar year).....	\$10
D1205	Topical application of fluoride (including prophylaxis) - adult (once per calendar year).....	\$10
D1310	Nutritional counseling for the control of dental disease.....	\$0
D1320	Tobacco counseling for the control and prevention of oral disease.....	NTCV
D1330	Oral hygiene instruction.....	\$0
D1351	Sealant - per tooth (under age 18 only).....	NTCV
D1510	Space maintainer - fixed - unilateral.....	\$55
D1515	Space maintainer - fixed - bilateral.....	\$55
D1520	Space maintainer - removable - unilateral.....	\$55
D1525	Space maintainer - removable - bilateral.....	\$55
D1550	Recementation of space maintainer.....	\$0
III. RESTORATIVE		
D2110	Amalgam - 1 surface, primary.....	\$14
D2120	Amalgam - 2 surfaces, primary.....	\$18
D2130	Amalgam - 3 surfaces, primary.....	\$22
D2131	Amalgam - 4 or more surfaces, primary.....	\$28
D2140	Amalgam - 1 surface, permanent.....	\$15
D2150	Amalgam - 2 surfaces, permanent.....	\$20
D2160	Amalgam - 3 surfaces, permanent.....	\$26
D2161	Amalgam - 4 or more surfaces, permanent.....	\$34
D2330	Resin-based composite - 1 surface, anterior.....	\$25
D2331	Resin-based composite - 2 surfaces, anterior.....	\$25
D2332	Resin-based composite - 3 surfaces, anterior.....	\$25
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior).....	\$28
D2336	Resin-based composite crown - anterior-primary.....	NTCV
D2337	Resin-based composite crown - anterior-permanent.....	NTCV
D2380	Resin-based composite - 1 surface, posterior-primary.....	\$49
D2381	Resin-based composite - 2 surfaces, posterior-primary.....	\$61
D2382	Resin-based composite - 3 or more surfaces, posterior-primary.....	\$63
D2385	Resin-based composite - 1 surface, posterior-permanent.....	\$66
D2386	Resin-based composite - 2 surfaces, posterior-permanent.....	\$85
D2387	Resin-based composite - 3 or more surfaces, posterior-permanent.....	\$102
D2388	Resin-based composite - 4 or more surfaces, posterior-permanent.....	\$117
D2390	Resin-based composite crown, anterior.....	NTCV
D2391	Resin-based composite - 1 surface, posterior.....	\$66
D2392	Resin-based composite - 2 surfaces, posterior.....	\$85
D2393	Resin-based composite - 3 surfaces, posterior.....	\$102
D2394	Resin-based composite - 4 or more surfaces, posterior.....	\$117
D2410	Gold foil - 1 surface.....	\$15
D2420	Gold foil - 2 surfaces.....	\$20
D2430	Gold foil - 3 surfaces.....	\$26
D2510	Inlay - metallic - 1 surface *.....	\$75
D2520	Inlay - metallic - 2 surfaces *.....	\$90

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D2530	Inlay - metallic - 3 or more surfaces *	\$105
D2542	Onlay - metallic - 2 surfaces *	\$120
D2543	Onlay - metallic - 3 surfaces *	\$130
D2544	Onlay - metallic - 4 or more surfaces *	\$140
D2610	Inlay - porcelain/ceramic - 1 surface	NTCV
D2620	Inlay - porcelain/ceramic - 2 surfaces	NTCV
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	NTCV
D2642	Onlay - porcelain/ceramic - 2 surfaces	NTCV
D2643	Onlay - porcelain/ceramic - 3 surfaces	NTCV
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	NTCV
D2650	Inlay - resin-based composite - 1 surface	NTCV
D2651	Inlay - resin-based composite - 2 surfaces	NTCV
D2652	Inlay - resin-based composite - 3 or more surfaces	NTCV
D2662	Onlay - resin-based composite - 2 surfaces	NTCV
D2663	Onlay - resin-based composite - 3 surfaces	NTCV
D2664	Onlay - resin-based composite - 4 or more surfaces	NTCV
D2710	Crown - resin (laboratory) †	\$85
D2712	Crown - 3/4 resin-based composite (indirect) †	\$85
D2720	Crown - resin with high noble metal * †	\$110
D2721	Crown - resin with predominantly base metal †	\$110
D2722	Crown - resin with noble metal * †	\$110
D2740	Crown - porcelain/ceramic substrate - non-molar †	\$130
D2750	Crown - porcelain fused to high noble metal - non-molar * †	\$165
D2750	Crown - porcelain fused to high noble metal - molar * †	\$245
D2751	Crown - porcelain fused to predominantly base metal - non-molar †	\$165
D2751	Crown - porcelain fused to predominantly base metal - molar †	\$245
D2752	Crown - porcelain fused to noble metal - non-molar * †	\$165
D2752	Crown - porcelain fused to noble metal - molar * †	\$245
D2780	Crown - 3/4 cast high noble metal * †	\$140
D2781	Crown - 3/4 cast predominantly base metal †	\$140
D2782	Crown - 3/4 cast noble metal * †	\$140
D2783	Crown - 3/4 porcelain/ceramic (facial veneers not included) †	\$98
D2790	Crown - full cast high noble metal * †	\$145
D2791	Crown - full cast predominantly base metal †	\$145
D2792	Crown - full cast noble metal * †	\$145
D2794	Crown - titanium* †	\$145
D2799	Provisional crown †	NTCV
D2910	Recement inlay	\$12
D2915	Recement cast or prefabricated post and core	\$12
D2920	Recement crown	\$12
D2930	Prefabricated stainless steel crown - primary tooth	\$30
D2931	Prefabricated stainless steel crown - permanent tooth	\$45
D2932	Prefabricated resin crown	\$45
D2933	Prefabricated stainless steel crown with resin window	NTCV
D2940	Sedative filling	\$7
D2950	Core buildup (including any pins)	\$0
D2951	Pin retention - per tooth, in addition to restoration	\$5
D2952	Cast post and core in addition to crown*	\$65
D2953	Each additional cast post - same tooth	\$52
D2954	Prefabricated post and core in addition to crown	\$50
D2955	Post removal (not in conjunction with endodontic therapy)	NTCV
D2957	Each additional prefabricated post - same tooth (to be used with D2954)	\$40

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D2960	Labial veneer (lamine) - chairside	NTCV
D2961	Labial veneer (resin lamine) - laboratory	NTCV
D2962	Labial veneer (porcelain lamine) - laboratory	NTCV
D2970	Temporary crown, fractured tooth (as a palliative service not in conjunction with a new permanent crown being done)	\$0
D2971	Additional procedures to construct new crown under existing partial denture framework	\$100
D2975	Coping	\$73
D2980	Crown repair, by report	NTCV
D2999	Unspecified restorative procedure, by report	NTCV
IV. ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	\$10
D3120	Pulp cap - indirect (excluding final restoration)	\$24
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$22
D3221	Pulpal debridement, primary and permanent teeth	\$22
D3222	Partial pulpotomy	\$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	NTCV
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	NTCV
D3310	Root canal therapy - anterior (excluding final restoration)	\$100
D3320	Root canal therapy - bicuspid (excluding final restoration)	\$130
D3330	Root canal therapy - molar (excluding final restoration)	\$175
D3331	Treatment of root canal obstruction; non-surgical access	NTCV
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	\$88
D3333	Internal root repair of perforation defects	NTCV
D3346	Retreatment of previous root canal therapy - anterior	\$100
D3347	Retreatment of previous root canal therapy - bicuspid	\$130
D3348	Retreatment of previous root canal therapy - molar	\$175
D3351	Apexification/recalcification, initial visit	NTCV
D3352	Apexification/recalcification, interim medication replacement	NTCV
D3353	Apexification/recalcification, final visit	NTCV
D3410	Apicoectomy/periradicular surgery - anterior	\$100
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$100
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$100
D3426	Apicoectomy/periradicular surgery (each additional root)	\$100
D3430	Retrograde filling - per root	\$0
D3450	Root amputation - per root	NTCV
D3460	Endodontic endosseous implant	NTCV
D3470	Intentional reimplantation (including necessary splinting)	NTCV
D3910	Surgical procedure for isolation of tooth with rubber dam	NTCV
D3920	Hemisection (including any root removal) - not including root canal therapy	NTCV
D3950	Canal preparation and fitting of performed dowel or post	\$0
D3960	Bleaching of discolored tooth	NTCV
D3999	Unspecified endodontic procedure, by report	NTCV
V. PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - per quadrant	\$115
D4211	Gingivectomy or gingivoplasty - per tooth	\$20
D4220	Gingival curettage, surgical, per quadrant, by report (no charge if D4341 on same quadrant and same day)	\$40
D4240	Gingival flap procedure, including root planing - 4 or more teeth, per quadrant	\$200
D4241	Gingival flap procedure, including root planing - 1 to 3 teeth, per quadrant	\$100
D4245	Apically positioned flap	NTCV

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Code	Procedure	Copayment
D4249	Clinical crown lengthening - hard tissue	NTCV
D4250	Mucogingival surgery - per quadrant	\$200
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces, per quadrant	\$200
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces, per quadrant	\$100
D4263	Bone replacement graft - first site in quadrant	NTCV
D4264	Bone replacement graft - each additional site in quadrant	NTCV
D4265	Biologic materials to aid in soft and osseous tissue regeneration	NTCV
D4266	Guided tissue regeneration - resorbable barrier, per site.....	NTCV
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	NTCV
D4268	Surgical revision procedure, per tooth	NTCV
D4270	Pedicle soft tissue graft procedure.....	NTCV
D4271	Free soft tissue graft procedure (including donor site surgery)	NTCV
D4273	Subepithelial connective tissue graft procedure (including donor site surgery)	NTCV
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	NTCV
D4275	Soft tissue allograft	NTCV
D4276	Combined connective tissue and double pedicle graft.....	NTCV
D4320	Provisional splinting - intracoronal	NTCV
D4321	Provisional splinting - extracoronal	NTCV
D4341	Periodontal scaling and root planing - 4 or more teeth, per quadrant (max of 4 quadrants per calendar year)	\$40
D4342	Periodontal scaling and root planing - 1 to 3 teeth, per quadrant (max of 4 quadrants per calendar year)	\$20
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	\$40
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	NTCV
D4910	Periodontal maintenance procedures (following active therapy; once every 6 months)	\$20
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$0
D4999	Unspecified periodontal procedure, by report.....	NTCV
VI. DENTURES (PROSTHODONTICS, REMOVABLE)		
D5110	Complete denture - maxillary *	\$250
D5120	Complete denture - mandibular *	\$250
D5130	Immediate denture - maxillary *	\$250
D5140	Immediate denture - mandibular *	\$250
D5211	Maxillary partial denture - resin base (including any conventional claspa, rests and teeth) *	\$225
D5212	Mandibular partial denture - resin base (including any conventional claspa, rests and teeth) *	\$225
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	\$255
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	\$255
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) *	\$225
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) *	\$225
D5281	Removable unilateral partial denture - 1-piece cast metal (including clasps and teeth) *	\$255
D5410	Adjust complete denture - maxillary	\$12
D5411	Adjust complete denture - mandibular	\$12
D5421	Adjust partial denture - maxillary	\$12
D5422	Adjust partial denture - mandibular	\$12
D5510	Repair broken complete denture base	\$28
D5520	Replace missing or broken teeth - complete denture (each tooth) *	\$23
D5610	Repair resin denture base	\$28
D5620	Repair cast framework.....	\$28

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Code	Procedure	Copayment
D5630	Repair or replace broken clasp	\$31
D5640	Replace broken teeth - per tooth *	\$31
D5650	Add tooth to existing partial denture *	\$31
D5660	Add clasp to existing partial denture	\$31
D5670	Replace all teeth and acrylic on cast metal framework (maxillary) *	\$128
D5671	Replace all teeth and acrylic on cast metal framework (mandibular) *	\$128
D5710	Rebase complete maxillary denture	NTCV
D5711	Rebase complete mandibular denture	NTCV
D5720	Rebase maxillary partial denture	NTCV
D5721	Rebase mandibular partial denture	NTCV
D5730	Reline complete maxillary denture (chairside)	\$35
D5731	Reline complete mandibular denture (chairside)	\$35
D5740	Reline maxillary partial denture (chairside)	\$35
D5741	Reline mandibular partial denture (chairside)	\$35
D5750	Reline complete maxillary denture (laboratory)	\$65
D5751	Reline complete mandibular denture (laboratory)	\$65
D5760	Reline maxillary partial denture (laboratory)	\$65
D5761	Reline mandibular partial denture (laboratory)	\$65
D5810	Interim complete denture (maxillary)	NTCV
D5811	Interim complete denture (mandibular)	NTCV
D5820	Interim partial denture (maxillary)	\$60
D5821	Interim partial denture (mandibular)	\$60
D5850	Tissue conditioning, maxillary	NTCV
D5851	Tissue conditioning, mandibular	NTCV
D5860	Overdenture - complete, by report	NTCV
D5861	Overdenture - partial, by report	NTCV
D5862	Precision attachment, by report	NTCV
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	NTCV
D5875	Modification of removable prosthesis following implant surgery	NTCV
D5899	Unspecified removable prosthodontic procedure, by report	NTCV
VII. MAXILLOFACIAL PROSTHETICS		
D5900 - D5999	Maxillofacial prosthetics	NTCV
VIII. IMPLANT SERVICES		
D6000 - D6199	Implant services	NTCV
IX. BRIDGES (PROSTHODONTICS, FIXED)†		
D6210	Pontic - cast high noble metal * †	\$145
D6211	Pontic - cast predominantly base metal †	\$145
D6212	Pontic - cast noble metal * †	\$145
D6214	Pontic - titanium * †	\$145
D6240	Pontic - porcelain fused to high noble metal * †	\$165
D6241	Pontic - porcelain fused to predominantly base metal †	\$165
D6242	Pontic - porcelain fused to noble metal * †	\$165
D6245	Pontic - porcelain/ceramic †	\$165
D6250	Pontic - resin with high noble metal * †	\$125
D6251	Pontic - resin with predominantly base metal †	\$125
D6252	Pontic - resin with noble metal * †	\$125
D6253	Provisional pontic †	NTCV
D6519	Bridge retainer - inlay/onlay - porcelain/ceramic †	NTCV
D6520	Bridge retainer - inlay - metallic - 2 surfaces * †	\$90
D6530	Bridge retainer - inlay - metallic - 3 or more surfaces * †	\$105
D6543	Bridge retainer - onlay - metallic - 3 surfaces * †	\$130

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Code	Procedure	Copayment
D6544	Bridge retainer - onlay - metallic - 4 or more surfaces * †	\$140
D6545	Bridge retainer - cast metal for resin bonded fixed prosthesis †	NTCV
D6548	Bridge retainer - porcelain/ceramic for resin bonded fixed prosthesis †	NTCV
D6600	Bridge retainer - inlay - porcelain/ceramic, 2 surfaces †	NTCV
D6601	Bridge retainer - inlay - porcelain/ceramic, 3 or more surfaces †	NTCV
D6602	Bridge retainer - inlay - cast high noble metal, 2 surfaces * †	\$90
D6603	Bridge retainer - inlay - cast high noble metal, 3 or more surfaces * †	\$105
D6604	Bridge retainer - inlay - cast predominantly base metal, 2 surfaces †	\$90
D6605	Bridge retainer - inlay - cast predominantly base metal, 3 or more surfaces †	\$105
D6606	Bridge retainer - inlay - cast noble metal, 2 surfaces * †	\$90
D6607	Bridge retainer - inlay - cast noble metal, 3 or more surfaces * †	\$105
D6608	Bridge retainer - onlay - porcelain/ceramic, 2 surfaces †	NTCV
D6609	Bridge retainer - onlay - porcelain/ceramic, 3 or more surfaces †	NTCV
D6610	Bridge retainer - onlay - cast high noble metal, 2 surfaces * †	\$120
D6611	Bridge retainer - onlay - cast high noble metal, 3 or more surfaces * †	\$130
D6612	Bridge retainer - onlay - cast predominantly base metal, 2 surfaces †	\$120
D6613	Bridge retainer - onlay - cast predominantly base metal, 3 or more surfaces †	\$130
D6614	Bridge retainer - onlay - cast noble metal, 2 surfaces * †	\$120
D6615	Bridge retainer - onlay - cast noble metal, 3 or more surfaces * †	\$130
D6624	Bridge retainer - inlay - titanium * †	\$105
D6634	Bridge retainer - onlay - titanium * †	\$130
D6720	Bridge retainer - crown - resin with high noble metal * †	\$110
D6721	Bridge retainer - crown - resin with predominantly base metal †	\$110
D6722	Bridge retainer - crown - resin with noble metal * †	\$110
D6740	Bridge retainer - crown - porcelain/ceramic †	\$130
D6750	Bridge retainer - crown - porcelain fused to high noble metal * †	\$165
D6751	Bridge retainer - crown - porcelain fused to predominantly base metal †	\$165
D6752	Bridge retainer - crown - porcelain fused to noble metal * †	\$165
D6780	Bridge retainer - crown - 3/4 cast high noble metal * †	\$140
D6781	Bridge retainer - crown - 3/4 cast predominantly base metal †	\$140
D6782	Bridge retainer - crown - 3/4 cast noble metal * †	\$140
D6783	Bridge retainer - crown - 3/4 porcelain/ceramic †	\$140
D6790	Bridge retainer - crown - full cast high noble metal * †	\$145
D6791	Bridge retainer - crown - full cast predominantly base metal †	\$145
D6792	Bridge retainer - crown - full cast noble metal * †	\$145
D6793	Bridge retainer - provisional retainer crown †	NTCV
D6794	Bridge retainer - crown - titanium * †	\$145
D6920	Connector bar †	NTCV
D6930	Recement bridge †	\$18
D6940	Stress breaker †	NTCV
D6950	Precision attachment †	NTCV
D6970	Cast post and core in addition to bridge retainer * †	\$65
D6971	Cast post as part of bridge retainer * †	\$50
D6972	Prefabricated post and core in addition to bridge retainer †	\$50
D6973	Core buildup for bridge retainer (including any pins) †	\$0
D6975	Coping - metal * †	\$0
D6976	Each additional cast post - same tooth * †	\$52
D6977	Each additional prefabricated post - same tooth †	\$40
D6980	Bridge repair, by report †	NTCV
D6985	Pediatric partial denture, fixed †	NTCV
D6999	Unspecified, fixed prosthodontic procedure, by report †	NTCV

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X. ORAL AND MAXILLOFACIAL SURGERY

D7110	Extraction - single tooth - not solely for ortho	\$16
D7111	Coronal remnants - deciduous tooth	\$10
D7120	Each additional tooth, same visit - not solely for ortho	\$10
D7130	Root removal - exposed roots	\$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$16
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth ...	\$40
D7220	Removal of impacted tooth - soft tissue	\$50
D7230	Removal of impacted tooth - partially bony	\$65
D7240	Removal of impacted tooth - completely bony	\$90
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	\$90
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$40
D7260	Oroantral fistula closure.....	NTCV
D7261	Primary closure of a sinus perforation	NTCV
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	NTCV
D7272	Tooth transplantation (includes reimplantation from 1 site to another and splinting and/or stabilization)	NTCV
D7280	Surgical access of an unerupted tooth	NTCV
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	NTCV
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	NTCV
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$16
D7286	Biopsy of oral tissue - soft (all others).....	\$10
D7287	Cytology sample collection	NTCV
D7290	Surgical repositioning of teeth	NTCV
D7291	Transseptal fibrotomy/supra crestal fibrotomy, by report	NTCV
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$90
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant.....	\$68
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$80
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant.....	\$60
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	NTCV
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	NTCV
D7410	Excision of benign lesion up to 1.25 cm	NTCV
D7411	Excision of benign lesion greater than 1.25 cm	NTCV
D7412	Excision of benign lesion, complicated	NTCV
D7413	Excision of malignant lesion up to 1.25 cm	NTCV
D7414	Excision of malignant lesion greater than 1.25 cm	NTCV
D7415	Excision of malignant lesion, complicated	NTCV
D7420	Radical excision - lesion diameter greater than 1.25 cm	NTCV
D7430	Excision of benign tumor - lesion diameter up to 1.25 cm	NTCV
D7431	Excision of benign tumor - lesion diameter greater than 1.25 cm	NTCV
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	NTCV
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	NTCV
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	NTCV
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	NTCV
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	NTCV
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	NTCV
D7465	Destruction of lesion(s) by physical or chemical method, by report	NTCV
D7470	Removal of exostosis - maxilla or mandible	\$115
D7471	Removal of exostosis - per site	\$115
D7472	Removal of torus palatinus	\$115
D7473	Removal of torus mandibularis.....	\$115
D7480	Partial ostectomy (guttering or saucerization)	NTCV

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade

† = Over age 15; limited to 7 crowns and/or pontics in any 12-month period; any single fixed bridge is limited to 4 units in length

NTCV = The procedure is **Not a Covered Benefit** under this plan

\$0 = No Charge for this procedure under this plan

Code	Procedure	Copayment
D7485	Surgical reduction of osseous tuberosity	\$115
D7490	Radical resection of mandible with bone graft.....	NTCV
D7510	Incision and drainage of abscess - intraoral soft tissue	\$30
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).....	\$45
D7520	Incision and drainage of abscess - extraoral soft tissue	\$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces).....	\$45
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue.....	NTCV
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system	NTCV
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.....	NTCV
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	NTCV
D7610 - D7680	Treatment of fractures - simple	NTCV
D7710 - D7780	Treatment of fractures - compound.....	NTCV
D7810 - D7899	Reduction of dislocation and management of other temporomandibular joint dysfunctions	NTCV
D7910	Suture of recent small wounds - up to 5 cm	NTCV
D7911	Complicated suture - up to 5 cm	NTCV
D7912	Complicated suture - greater than 5 cm	NTCV
D7920 - D7949	Other repair procedures	NTCV
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report ..	NTCV
D7955	Repair of maxillofacial soft and hard tissue defects	NTCV
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$50
D7970	Excision of hyperplastic tissue - per arch	NTCV
D7971	Excision of pericoronal gingiva.....	NTCV
D7972	Surgical reduction of fibrous tuberosity	\$115
D7980	Sialolithotomy.....	NTCV
D7981	Excision of salivary gland, by report	NTCV
D7982	Sialodochoplasty.....	NTCV
D7983	Closure of salivary fistula.....	NTCV
D7990	Emergency tracheotomy	NTCV
D7991	Coronoidectomy.....	NTCV
D7995	Synthetic graft - mandible or facial bones, by report	NTCV
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	NTCV
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	NTCV
D7999	Unspecified oral surgery procedure, by report	NTCV

XI. ORTHODONTICS

D8000 - D8999 See special Orthodontia program information attached to this Schedule of Benefits

XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedures.....	\$10
D9210	Local anesthesia not in conjunction with operative or surgical procedures	NTCV
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia.....	\$0
D9215	Local anesthesia	\$0
D9220	General anesthesia - first 30 minutes (limited to covered oral surgical procedures involving 1 or more impacted teeth: soft tissue, partially bony or completely bony impactions).....	\$125
D9221	General anesthesia - each additional 15 minutes	\$60
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	NTCV
D9241	Intravenous sedation/analgesia - first 30 minutes	\$140
D9242	Intravenous sedation/analgesia - each additional 15 minutes	\$70
D9248	Non-intravenous conscious sedation	NTCV
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$25

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade

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NTCV = The procedure is **Not a Covered Benefit** under this plan

\$0 = No Charge for this procedure under this plan

Code	Procedure	Copayment
D9410	House/extended care facility call.....	NTCV
D9420	Hospital call.....	NTCV
D9430	Office visit (during regularly scheduled hours) - no other services performed	\$0
D9440	Office visit - after regularly scheduled hours	\$20
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9610	Therapeutic drug injection, by report	NTCV
D9630	Other drugs and/or medicaments, by report.....	NTCV
D9910	Application of desensitizing medicament.....	NTCV
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	NTCV
D9920	Behavior management, by report.....	NTCV
D9930	Treatment of complication (post-surgical) - unusual circumstances, by report	\$0
D9940	Occlusal guards, by report	NTCV
D9941	Fabrication of athletic mouthguard.....	NTCV
D9950	Occlusion analysis - mounted case	NTCV
D9951	Occlusal adjustment - limited	\$0
D9952	Occlusal adjustment - complete	NTCV
D9970	Enamel Microabrasion.....	NTCV
D9971	Odontoplasty 1 to 2 teeth; includes removal of enamel projections	NTCV
D9972	External bleaching - per arch	NTCV
D9973	External bleaching - per tooth	NTCV
D9974	Internal bleaching - per tooth	NTCV
D9999	Unspecified adjunctive procedure, by report	NTCV
—	Broken Appointment, with no prior notification at least 24 hours before the scheduled appointment	\$20
—	Specialty family calendar year maximum	\$1000

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade

†= Over age 15; limited to 7 crowns and/or pontics in any 12-month period; any single fixed bridge is limited to 4 units in length

NTCV = The procedure is **Not a Covered Benefit** under this plan

\$0 = No Charge for this procedure under this plan

IMPORTANT INFORMATION ABOUT YOUR DENTAL PLAN

EMERGENCY CARE/In Area or Out of Area

Your Assigned Dental Provider Group will be available for Emergency Dental Care 24 hours a day, 7 days a week.

If you need Emergency Dental Care (for example, due to pain, bleeding or swelling, infection or drainage) you must contact your Assigned Dental Provider Group. If you are outside UnitedHealthcare Dental's Service Area and in need of Urgent Dental Services or if your acute emergent dental condition prevents you from contacting your Assigned Dental Provider Group, you may receive care by any licensed dentist. However, you must use the emergency dentist ONLY for relief of pain, or to immediately diagnose and treat a condition that a reasonable person with no special knowledge of dentistry under the circumstance would believe that, if not given immediate attention, may seriously jeopardize the health of the member, seriously impair bodily functions, or result in serious dysfunction of a bodily organ or part. UnitedHealthcare Dental will cover out-of-area follow-up care by a Non-Participating Provider as long as the care continues to meet the definition of Emergency Dental Care.

We will reimburse you for these covered Emergency Dental Services only, subject to applicable Copayments. To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were necessary. We will provide reimbursement within 30 days of receipt.

All reimbursement requests should be mailed to:

UnitedHealthcare Dental, M/S LC05-293
P.O. Box 25187
Santa Ana, CA 92799-5187

EXCLUSIONS

(Refer to *Combined Evidence of Coverage and Disclosure Form* booklet for plan Limitations.) The following procedures and services are excluded and not covered Services:

1. Specialty referral benefits, unless otherwise indicated in the Schedule of Benefits, are not covered.
2. Services provided by a prosthodontist are not covered.
3. Cosmetic dental care is not covered.
4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Member's Assigned Dental Provider Group, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
5. Treatment of fractured bones and dislocated joints is not covered.
6. Lost or stolen dentures are not covered.
7. Crowns, or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances are not covered.
9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.
10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with UnitedHealthcare Dental, whichever is earlier, or started by a Non-Participating Provider without the prior approval of UnitedHealthcare Dental is not covered. This exclusion does not apply to a current Member:
 - who has temporary restorative services
 - whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.

14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue is not covered.
15. Prescription drugs and over-the-counter medicines are not covered.
16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in the Combined Evidence of Coverage and Disclosure Form.
19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered.
22. Replacement of amalgam restorations with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not covered Services. If performed, the patient must pay the dentist's Billed Charges. These services include:
 - Realignment of teeth
 - Gnathologic recording
 - Equilibration
 - Occlusal splints and night guards
 - Overlays, implant supported partial dentures and overdentures
 - The replacement of otherwise serviceable existing restorations and dental prosthetics
 - Precision attachments and stressbreakers
24. Dental services that the Plan determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N2O2 - nitrous oxide) is not covered.

HEALTH PLAN BENEFITS AND COVERAGE MATRIX (GROUP PLANS)

This Matrix Is Intended To Be Used To Help You Compare Coverage Benefits And Is A Summary Only. The Combined Evidence Of Coverage And Disclosure Form And Plan Contract Should Be Consulted For A Detailed Description Of Coverage Benefits And Limitations.

This Uniform Matrix supersedes any other such matrix in the Combined Evidence Of Coverage and Disclosure Form which describes the Plan benefits.

Benefit Description

Corresponding Copayments or Limitations

Deductibles:

There are no deductibles.

Lifetime Maximums:

There are no lifetime maximums.

Calendar Year Maximums:

There is a Calendar Year Maximum of \$1000

Professional Services:

Comprehensive Oral Exam	No Charge
Periodic Oral Exam	No Charge
Intraoral X-rays	No Charge
Prophylaxis	No Charge (once every 6 months)
Topical Application of Fluoride (under 18)	No Charge
Amalgam Fillings (primary and permanent teeth)	\$14 to \$34 (dependent upon number of tooth surfaces)
Resin fillings (front teeth only)	\$25 to \$28 (dependent upon number of tooth surfaces)
Crowns (single restorations not associated with a bridge)	\$85 to \$245 per unit (dependent upon materials used) plus actual lab cost of precious metal and/or other material upgrade
Root Canal	\$100 to \$175 (dependent upon tooth number)
Apicoectomy	\$100
Gingivectomy	\$115 per quadrant
Gingival Curettage	\$40 per quadrant
Crown Lengthening	Not a covered benefit of this plan.
Periodontal Root Planing and Scaling	\$40 per quadrant
Full Mouth Debridement	\$40
Full Mouth Dentures (either immediate or complete)	\$250 for upper, \$250 for lower
Partials (upper/lower)	\$225 to \$255 each (dependent upon material)
Bridges (pontics/abutment crowns)	\$125 to \$165 per unit plus actual lab cost of precious metal and/or other material upgrade
Extractions (not for orthodontic purposes)	\$16 to \$90 (dependent upon type of extraction)

Outpatient Services:

Please see Professional Services listed above.

Hospitalization Services:

Not a covered benefit of this plan.

Emergency Services: (after-hours office-visit fee when applicable)

In Area: Assigned provider is responsible to provide emergency care 24 hours a day/7 days a week.

\$5 to \$20 copayment for relief of pain.

Out of Area: If your acute emergent dental condition prevents you from contacting your assigned dentist, you may receive care by any licensed dentist. The Plan will reimburse you for covered emergency services only, subject to applicable copayments.

Ambulance Services:

Not a covered benefit of this plan.

Prescription Drug Coverage:

Not a covered benefit of this plan.

Durable Medical Equipment:

Not a covered benefit of this plan.

Mental Health Services:

Not a covered benefit of this plan.

Chemical Dependency Services:

Not a covered benefit of this plan.

Home Health Services:

Not a covered benefit of this plan.

SAMPLE PEDODONTIC SPECIALTY BENEFITS

- requires referral from your Assigned Dental Provider Group
- subject to specialty family calendar year maximum
- benefits apply through age 18

Copayments listed in this Schedule of Benefits do not apply to Covered Services provided by a pedodontist. Instead, the parent or guardian is responsible for 49% of the pedodontist's contracted rate, as shown in the samples below.

Code	Procedure	Approximate Range of Provider Charges	Patient Copayment
00120	Oral Exam	\$10-\$54	49% of Provider Charges
00140	Limited Oral	\$65	49% of Provider Charges
00150	Comp Oral	\$35-\$72	49% of Provider Charges
00210	Intraoral X-ray	\$39-\$67	49% of Provider Charges
00220	Periapical	\$18-\$33	49% of Provider Charges
00230	Periapical Additional	\$5-\$60	49% of Provider Charges
00240	Occlusal	\$30	49% of Provider Charges
00270	Bitewing-Single	\$10	49% of Provider Charges
00272	Bitewing-Two	\$12-\$60	49% of Provider Charges
00274	Bitewing-Four	\$50	49% of Provider Charges
00330	Panoramic	\$68	49% of Provider Charges
01120	Child Prophy	\$12-65	49% of Provider Charges
01201	Child Prophy w/Fluoride	\$34-\$82	49% of Provider Charges
01203	Child Fluoride	\$6-\$25	49% of Provider Charges
01351	Sealant-Per Tooth	\$5-\$55	49% of Provider Charges
01510	Space Maintainer-Unilateral	\$240-\$348	49% of Provider Charges
01515	Space Maintainer-Bilateral	\$270-\$332	49% of Provider Charges
02110	Amalgam-One	\$50-\$75	49% of Provider Charges
02120	Amalgam-Two	\$42-\$108	49% of Provider Charges
02130	Amalgam-Three	\$93-\$125	49% of Provider Charges
02140	Amalgam-One-Perm	\$75-\$82	49% of Provider Charges
02330	Resin-One	\$100-\$130	49% of Provider Charges
02331	Resin-Two	\$100-\$115	49% of Provider Charges
02335	Resin-Four	\$215	49% of Provider Charges
02380	Resin-One-Posterior	\$42-\$62	49% of Provider Charges
02381	Resin-Two-Posterior-Prim	\$144	49% of Provider Charges
02385	Resin-One-Posterior-Perm	\$119	49% of Provider Charges
02930	Stainless Steel Crown-Prim	\$85-\$250	49% of Provider Charges
03110	Pulp Cap-Direct	\$40	49% of Provider Charges
03220	Pulpotomy	\$83-\$125	49% of Provider Charges
07110	Extraction-Single	\$45-\$125	49% of Provider Charges
07120	Extraction-Additional Teeth	\$70-\$125	49% of Provider Charges
09310	Consultation	\$5-\$55	49% of Provider Charges
09440	Office Visit-After Hours	\$75-\$100	49% of Provider Charges
09930	Tx of Complications	\$85	49% of Provider Charges

ORTHODONTIA program

Questions?

Call our Member Service department at
1-800-22-TEETH (1-800-228-3384)

Visit our Web site at www.myuhcdental.com



ORTHODONTICS (BRACES)³

To take advantage of the UnitedHealthcare SignatureValue group dental orthodontic benefit, a member must:

- Be an eligible employee or dependent currently enrolled in a UnitedHealthcare SignatureValue dental plan;
- Not be subject to any exclusion listed for orthodontic coverage;
- Have a written referral to a contracted UnitedHealthcare Dental orthodontist, submitted by the assigned dental Provider Group.

UnitedHealthcare Dental Orthodontic Benefits:

1. Startup services including:

- Panorgraphic radiographs.
- All required tracings.
- All diagnostic study models.
- All photographs.
- All case studies.

Member copayment: \$250

(Services performed by outside laboratories are not a benefit; therefore, the cost is entirely the member's responsibility.)

2. All treatment performed during a 24-month period, including:

- Consultations and all office visits.
- Fixed and/or removable appliances (including headgear) required to adequately complete treatment in a satisfactory manner, subject to the limitations and exclusions of the plan.
- Banding.
- Retention, if required within a 24-month covered treatment period.

Member copayment: \$1895 for both upper and lower arch
\$947.50 for upper or lower arch only

If orthodontic treatment requires more than 24 months, members may be charged the orthodontist's regular fees for additional monthly visits as needed, as well as copayments for retention (see item #3 below).

3. Retention is included in the full treatment copayment if started during the 24-month active treatment coverage period. If retention is begun after the 24-month treatment period, then an additional retention copayment is applicable.

Member copayment: \$250 for children up to age 18
(includes upper and lower retainers);
\$300 for adults age 18 and older
(includes upper and lower retainers)

4. Final records, if required by your orthodontist, including photographs, models, radiographs or other studies.

Member copayment: \$150

(Services performed by outside laboratories are not a benefit; therefore, the cost is entirely the member's responsibility.)

5. The following are not covered orthodontic benefits:

- Lost, stolen, or broken appliances
- Treatment in progress prior to the effective date of UnitedHealthcare Dental coverage
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Cleft palate
- Micrognathia
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan
- Palatal expansion appliances

6. If a treatment plan is for less than 24 months, then a prorated portion of the full member copayment shall apply.

7. If member's dental eligibility ends, for whatever reason, and the member is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The member will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

8. If the member has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the member will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.

9. A member is eligible for only one 24-month orthodontic treatment period while covered under this Plan.

For orthodontic referrals, the following procedure applies:

The assigned dental Provider Group will complete a written referral form for the member and mail it to UnitedHealthcare Dental. UnitedHealthcare Dental will process the referral request. The referral will be made to a specialist contracted with UnitedHealthcare Dental, who practices in the member's area. A copy of the processed referral is sent to the member, the referring dentist and the selected contracted orthodontist who has agreed to provide these services at reduced fees for UnitedHealthcare Dental members. The member can then call the Orthodontist and schedule an appointment.

³One orthodontic benefit under this plan is available per lifetime, per member. A member may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24-month period, the copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24-month benefit period.