



## LIBERTY Dental Plan CA80 COPAYMENT SCHEDULE

Code	Description	Member Copayment	Code	Description	Member Copayment
<b>Diagnostic Services</b>					
D0120	Periodic Oral Evaluation	8	D2920	Recement Crown	18
D0140	Limited Oral Evaluation	0	D2930	Prefab. Stain. St. Crown, Primary	50
D0150	Comprehensive Oral Evaluation	8	D2931	Prefab. Stain St. Crown, Perm.	50
D0210	Full Mouth X-rays	0	D2940	Sedative Filling	99
D0220	Periapical X-ray – first film	0	D2950	Core Buildup, Inc. Pins	99
D0230	Periapical X-ray – additional film	0	D2951	Pin Retention	30
D0240	Occlusal film	0	D2952	Cast Post & Core*	90
D0250	Extra-oral X-ray – first film	0	D2954	Prefab. Post & Core	90
D0260	Extra-oral X-ray – additional film	0	D2955	Post Removal	25
D0270	Bitewing X-ray – single film	0	<b>Endodontic Services</b>		
D0272	Bitewing X-ray – two films	0	D3110	Pulp Cap, Direct	20
D0274	Bitewing X-ray – four films	0	D3120	Pulp Cap, Indirect	20
D0330	Panoramic Film	0	D3220	Therapeutic Pulpotomy	40
D0460	Pulp Vitality Test	8	D3230	Pulpal Therapy, Primary Anterior	35
D0470	Diagnostic Casts	8	D3240	Pulpal Therapy, Primary Posterior	40
<b>Preventive Services</b>					
D1110	Prophylaxis – Adult	0	D3310	Root Canal, Anterior	150
D1120	Prophylaxis – Child	0	D3320	Root Canal, Bicuspid	190
D1201	Prophylaxis with Fluoride – Child	0	D3330	Root Canal, Molar	245
D1203	Fluoride w/o Prophylaxis – Child	0	D3346	Retreat Root Canal, Anterior	170
D1204	Fluoride w/o Prophylaxis – Adult	0	D3347	Retreat Root Canal, Bicuspid	220
D1205	Prophylaxis with Fluoride – Adult	0	D3348	Retreat Root Canal, Molar	255
D1330	Oral Hygiene Instruction	0	D3351	Apex./Recal. – Initial Visit	85
D1351	Sealant – Per Tooth	15	D3352	Apex./Recal. – Interim Visit	85
D1510	Space Maint. Fixed Unilateral	100	D3353	Apex./Recal. – Final Visit	85
D1515	Space Maint. Fixed Bilateral	100	D3410	Apicoectomy, Anterior	475
D1520	Space Maint. Remov. Unilateral	100	D3421	Apicoectomy, Bicuspid 1 <sup>st</sup> Root	475
D1525	Space Maint. Remov. Bilateral	100	D3425	Apicoectomy, Molar 1 <sup>st</sup> Root	475
D1550	Recement Space Maintainer	10	D3426	Apicoectomy, Each Add. Root	475
<b>Restorative Services</b>					
D2140	Amalgam, 1 Surface	25	D3430	Retrograde Filling, Per Root	100
D2150	Amalgam, 2 Surface	32	D3450	Root Amputation, Per Root	100
D2160	Amalgam, 3 Surface	42	<b>Periodontic Services</b>		
D2161	Amalgam, 4 Surface	53	D4210	Gingivectomy, 4+ Teeth per Quad.	220
D2330	Resin Comp., 1 Surface Anterior	38	D4211	Gingivectomy, 1-3 Teeth per Quad.	20
D2331	Resin Comp., 2 Surface Anterior	48	D4240	Ging. Flap Proc., 4+ Teeth per Quad.	300
D2332	Resin Comp., 3 Surface Anterior	58	D4241	Ging. Flap Proc., 1-3 Teeth per Quad.	300
D2335	Resin Comp., 4 Surface Anterior	68	D4260	Osseous Surg., 4+ Teeth per Quad.	650
D2391	Resin Comp., 1 Surface Posterior	45	D4261	Osseous Surg., 1-3 Teeth per Quad.	650
D2392	Resin Comp., 2 Surface Posterior	50	D4341	Scale & Root Plan, 4+ Teeth per Quad	60
D2393	Resin Comp., 3 Surface Posterior	55	D4342	Scale & Root Plan, 1-3 Teeth per Quad	60
<b>Crowns</b>					
D2740	Crown, Porc./Ceramic Substrate	280	D4355	Full Mouth Debridement	50
D2750	Crown, Porc./Hi Noble Metal*	280	D4910	Perio. Maint. Procedure	50
D2751	Crown, Porc./Base Metal*	280	<b>Removable Prosthodontics</b>		
D2752	Crown, Porc./Noble Metal*	280	D5110	Complete Upper Denture	385
D2780	Crown, ¾ Cast Hi Noble Metal*	240	D5120	Complete Lower Denture	385
D2781	Crown, ¾ Cast Base Metal*	240	D5130	Immed. Complete Upper Denture	385
D2782	Crown, ¾ Cast Noble Metal*	240	D5140	Immed. Complete Lower Denture	385
D2790	Crown, Full Cast Hi Noble Metal*	235	D5211	Upper Part. Denture, Resin Base	385
D2791	Crown, Full Cast Base Metal*	235	D5212	Lower Part. Denture, Resin Base	385
D2792	Crown, Full Cast Noble Metal*	235	D5213	Upper Part. Denture, Metal Frame	385
D2794	Crown, Titanium*	235	D5214	Lower Part. Denture, Metal Frame	385
D2910	Recement Inlay	18	D5410	Adjust Complete Upper Denture	22
			D5411	Adjust Complete Lower Denture	22
			D5421	Adjust Partial Denture, Upper	22
			D5422	Adjust Partial Denture, Lower	22
			D5510	Repair Broken Complete Denture Base	30

Code	Description	Member Copayment	Code	Description	Member Copayment
D5520	Replace Broken/Missing Tooth	35		<b>Adjunctive Services</b>	
D5610	Repair Resin Denture Base	35	D9110	Emerg. Pallative Treat., Minor	15
D5620	Repair Cast Framework	35	D9215	Local Anesthesia	0
D5630	Repair/Replace Broken Clasp	25	D9230	Analgesia, Nitrous Oxide, 1 <sup>st</sup> 15 Min.	45
D5640	Replace Broken Tooth, Per Tooth	25	D9230	Analgesia, Nitrous Oxide, Add. 15 Min.	25
D5650	Add Tooth to Partial Denture	30	D9310	Consultation	50
D5660	Add Clasp to Partial Denture	30	D9430	Office Visit, During Reg. Hrs., No Treat	0
D5710	Rebase Complete Upper Denture	75	D9440	Office visit, After Reg. Hrs.	20
D5711	Rebase Complete Lower Denture	75	D9630	Other Drugs and/or Medicaments	20
D5720	Rebase Upper Partial Denture	75	D9951	Occlusal Adjustment, Limited	20
D5721	Rebase Lower Partial Denture	75	D9952	Occlusal Adjustment, Complete	20
D5730	Reline Upper Denture, Chairside	60	D9999	Broken Appt., Less Than 24 Hr. Notice	10
D5731	Reline Lower Denture, Chairside	60	D9999	Office Visit, Per Visit	8
D5740	Reline Upper Part. Dent., Chairside	60		<b>Orthodontics</b>	
D5741	Reline Lower Part. Dent., Chairside	60		Removable Appliance Therapy	350
D5750	Reline Upper Denture, Lab.	90		(to age 18)	
D5751	Reline Lower Denture, Lab.	90		Fixed Appliance Therapy	350
D5760	Reline Upper Part. Denture, Lab.	90		(to age 18)	
D5761	Reline Lower Part. Denture, Lab.	90		Start-up Fees	175
D5820	Interim Partial Denture, Upper	90		(X-rays, Tracings, Case Studies, Study Models)	
D5821	Interim Partial Denture, Lower	90		Class I Malocclusion, Both Arches	2200
	<b>Fixed Prosthodontics</b>			Class I Malocclusion, 1 Arch	1100
D6210	Pontic, Cast Hi Noble Metal*	220		Class II Malocclusion, Both Arches	2300
D6211	Pontic, Cast Base Metal*	220		Class II Malocclusion, 1 Arch	1150
D6212	Pontic, Cast Noble Metal*	220		Class III Malocclusion, Both Arches	2300
D6214	Pontic, Titanium*	220		Class III Malocclusion, 1 Arch	1150
D6240	Pontic, Porc./Hi Noble Metal*	220		Post Treat. Stabilization, Child	300
D6241	Pontic, Porc./Base Metal*	280		Post Treat. Stabilization, Adult	350
D6242	Pontic, Porc./Noble Metal*	280			
D6750	Crown, Porc./Hi Noble Metal*	280			
D6751	Crown, Porc./Base Metal*	280			
D6752	Crown, Porc./Noble Metal*	280			
D6780	Crown, ¾ Cast Hi Noble Metal*	235			
D6781	Crown, ¾ Cast Base Metal*	235			
D6782	Crown, ¾ Cast Noble Metal*	235			
D6790	Crown, Cast Hi Noble Metal*	280			
D6791	Crown, Cast Base Metal*	280			
D6792	Crown, Cast Noble Metal*	280			
D6794	Crown, Titanium*	280			
D6930	Recement Fixed Partial Denture	35			
D6970	Cast Post & Core, In Addition*	99			
D6971	Cast Post & Core, As Part Of*	99			
D6972	Prefab. Post & Core	99			
D6973	Core Buildup, Inc. Pins	89			
	<b>Oral Surgery Services</b>				
D7140	Extraction, Erupt. Tooth or Root	28			
D7210	Surgical Extraction, Erupted Tooth	48			
D7220	Extraction, Soft Tissue Impaction	68			
D7230	Extraction, Partial Bony Impaction	100			
D7240	Extraction, Full Bony Impaction	130			
D7241	Extraction, Full Bony, Unusual	140			
D7250	Surgical Extraction, Residual Roots	70			
D7285	Biopsy of Oral Tissue, Hard	20			
D7286	Biopsy of Oral Tissue, Soft	20			
D7310	Alveoplasty with Ext., Per Quad.	35			
D7311	Alveoplasty with Ext., 1-3 Teeth	35			
D7320	Alveoplasty w/o Ext., Per Quad.	40			
D7321	Alveoplasty w/o Ext., 1-3 Teeth	40			
D7960	Frenectomy	20			
D7971	Excision Periocoronaral Gingiva	40			
				* Base metal is the benefit. Nobel, high noble, and titanium metal, if used, will be charged to the member at the additional laboratory cost of the noble, high noble, or titanium metal.	
				Resin, porcelain and any resin to metal or porcelain to metal crowns and pontics are a benefit on anterior and bicuspid teeth only.	
				<b>Member Services</b>	
				(888) 703-6999	
				Monday – Friday	
				8:00 a.m. – 5:00 p.m.	
				Pacific Time	

<b>SPECIALTY COPAYMENT SCHEDULE*</b>		<b>Member Copayment</b>	
<b>Endodontic Services</b>			<p><b>* LIBERTY Dental Plan will arrange for you to receive services from a Contracted Dental Specialist if the necessary treatment is outside the scope of General Dentistry. Your General Dentist will initiate the referral process with LIBERTY Dental Plan. The proper referral process must be utilized for specialty services to be covered under your plan. The Member Copayments listed on the left will apply when services are performed by a LIBERTY Dental Plan Specialist. X-rays for diagnostic purposes are benefits in the General Dentist's office only.</b></p>
D3310	Root Canal, Anterior	385	
D3320	Root Canal, Bicuspid	470	
D3330	Root Canal, Molar	580	
D3346	Retreat Root Canal, Anterior	385	
D3347	Retreat Root Canal, Bicuspid	470	
D3348	Retreat Root Canal, Molar	580	
D3410	Apicoectomy, Anterior	545	
D3421	Apicoectomy, Bicuspid 1 <sup>st</sup> Root	565	
D3425	Apicoectomy, Molar 1 <sup>st</sup> Root	485	
D3426	Apicoectomy, Each Add. Root	485	
D3420	Retrograde Filling, Per Root	170	
<b>Periodontic Services</b>			
D4260	Osseous Surgery, 4+ Teeth per Quad.	675	
D4261	Osseous Surgery, 1-3 Teeth per Quad.	675	
<b>Oral Surgery Services</b>			
D7210	Surgical Extraction, Erupted Tooth	145	
D7220	Extraction, Soft Tissue Impaction	165	
D7230	Extraction, Partial Bony Impaction	220	
D7240	Extraction, Full Bony Impaction	260	
D7241	Extraction, Full Bony, Unusual	290	
D7250	Surgical Extraction, Residual Roots	95	
D7285	Biopsy of Oral Tissue, Hard	195	
D7286	Biopsy of Oral Tissue, Soft	195	
D7310	Alveoloplasty with Ext., Per Quad.	130	
D7311	Alveoloplasty with Ext., 1-3 Teeth	130	
D7320	Alveoloplasty, w/o Ext., Per Quad.	160	
D7321	Alveoloplasty, w/o Ext., 1-3 Teeth	160	
D7471	Removal of Lateral Exostosis	260	

## Limitations

1. Prophylaxis are covered once every six consecutive months.
2. Full Mouth X-rays are limited to once every 36 consecutive months.
3. Fluoride Treatments are covered once every 6 consecutive months, up to the 18<sup>th</sup> birth date.
4. Sealants are covered only on the first and second permanent molars and up to the 14<sup>th</sup> birth date.
5. Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years, and consistent with professionally recognized standards of dental practice.
6. Replacement of existing Full and Partial Dentures are covered once per arch every 5 years, except when they cannot be made functional through relines or repairs.
7. Denture Relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice.
8. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

## Exclusions

1. Any procedure not specifically listed as a Covered Benefit
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit
4. Procedures considered experimental, treatment involving implants or pharmacological regimens (See "Independent Medical Review" on page 5)
5. Oral surgery requiring the setting of bone fractures or bone dislocations
6. Hospitalization
7. Out-patient services
8. Ambulance services
9. Durable Medical Equipment
10. Mental Health services
11. Chemical Dependency services
12. Home Health services
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist
14. Treatment started before the member was eligible, or after the member was no longer eligible
15. Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional(e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones) unless otherwise covered as an orthodontic benefit
16. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice
17. Treatment of malignancies, cysts, or neoplasms
18. Orthodontic treatment started prior to member's effective date of coverage
19. Appliances needed to increase vertical dimension or restore occlusion
20. Any services performed outside of your assigned dental office, unless expressly authorized by Liberty Dental Plan, or unless as outlined and covered in "Emergency Dental Care" section

## Orthodontic Exclusions

1. Lost, stolen or broken appliances
2. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition)
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics
4. Myofunctional therapy
5. Treatment of cleft palate
6. Treatment of micrognathia
7. Treatment of macroglossia