



LIBERTY Dental Plan CA10 COPAYMENT SCHEDULE

Code	Description	Member Copayment	Code	Description	Member Copayment
Diagnostic Services					
D0120	Periodic Oral Evaluation	5	D2910	Recement Inlay	0
D0140	Limited Oral Evaluation	0	D2920	Recement Crown	6
D0150	Comprehensive Oral Evaluation	0	D2930	Prefab. Stain. St. Crown, Primary	7
D0210	Full Mouth X-rays	0	D2931	Prefab. Stain St. Crown, Perm.	7
D0220	Periapical X-ray – first film	0	D2940	Sedative Filling	10
D0230	Periapical X-ray – additional film	0	D2950	Core Buildup, Inc. Pins	75
D0240	Occlusal film	0	D2951	Pin Retention	15
D0250	Extra-oral X-ray – first film	0	D2952	Cast Post & Core*	50
D0260	Extra-oral X-ray – additional film	0	D2954	Prefab. Post & Core	50
D0270	Bitewing X-ray – single film	0	D2955	Post Removal	20
D0272	Bitewing X-ray – two films	0	Endodontic Services		
D0274	Bitewing X-ray – four films	0	D3110	Pulp Cap, Direct	6
D0330	Panoramic Film	0	D3120	Pulp Cap, Indirect	6
D0460	Pulp Vitality Test	0	D3220	Therapeutic Pulpotomy	30
D0470	Diagnostic Casts	0	D3230	Pulpal Therapy, Primary Anterior	25
Preventive Services					
D1110	Prophylaxis – Adult	0	D3240	Pulpal Therapy, Primary Posterior	30
D1120	Prophylaxis – Child	0	D3310	Root Canal, Anterior	55
D1201	Prophylaxis with Fluoride – Child	0	D3320	Root Canal, Bicuspid	90
D1203	Fluoride w/o Prophylaxis – Child	0	D3330	Root Canal, Molar	150
D1204	Fluoride w/o Prophylaxis – Adult	0	D3346	Retreat Root Canal, Anterior	75
D1205	Prophylaxis with Fluoride – Adult	0	D3347	Retreat Root Canal, Bicuspid	110
D1330	Oral Hygiene Instruction	0	D3348	Retreat Root Canal, Molar	175
D1351	Sealant – Per Tooth	0	D3351	Apex./Recal. – Initial Visit	75
D1510	Space Maint. Fixed Unilateral	5	D3352	Apex./Recal. – Interim Visit	75
D1515	Space Maint. Fixed Bilateral	5	D3353	Apex./Recal. – Final Visit	75
D1520	Space Maint. Remov. Unilateral	5	D3410	Apicoectomy, Anterior	50
D1525	Space Maint. Remov. Bilateral	5	D3421	Apicoectomy, Bicuspid 1 st Root	50
D1550	Recement Space Maintainer	5	D3425	Apicoectomy, Molar 1 st Root	50
Restorative Services					
D2140	Amalgam, 1 Surface	0	D3426	Apicoectomy, Each Add. Root	50
D2150	Amalgam, 2 Surface	0	D3430	Retrograde Filling, Per Root	45
D2160	Amalgam, 3 Surface	0	D3450	Root Amputation, Per Root	45
D2161	Amalgam, 4 Surface	0	D3920	Hemisection, Not Incl. Root Canal	40
D2330	Resin Comp., 1 Surface Anterior	5	Periodontic Services		
D2331	Resin Comp., 2 Surface Anterior	10	D4210	Gingivectomy, 4+ Teeth per Quad.	50
D2332	Resin Comp., 3 Surface Anterior	15	D4211	Gingivectomy, 1-3 Teeth per Quad.	7
D2335	Resin Comp., 4 Surface Anterior	20	D4240	Ging. Flap Proc., 4+ Teeth per Quad.	200
D2390	Resin Comp. Crown, Anterior	30	D4241	Ging. Flap Proc., 1-3 Teeth per Quad.	200
D2391	Resin Comp., 1 Surface Posterior	25	D4260	Osseous Surg., 4+ Teeth per Quad.	250
D2392	Resin Comp., 2 Surface Posterior	35	D4261	Osseous Surg., 1-3 Teeth per Quad.	250
D2393	Resin Comp., 3 Surface Posterior	45	D4341	Scale & Root Plan, 4+ Teeth per Quad	50
Crowns					
D2740	Crown, Porc./Ceramic Substrate	140	D4342	Scale & Root Plan, 1-3 Teeth per Quad	50
D2750	Crown, Porc./Hi Noble Metal*	140	D4355	Full Mouth Debridement	50
D2751	Crown, Porc./Base Metal*	140	D4910	Perio. Maint. Procedure	40
D2752	Crown, Porc./Noble Metal*	170	Removable Prosthodontics		
D2780	Crown, ¾ Cast Hi Noble Metal*	165	D5110	Complete Upper Denture	140
D2781	Crown, ¾ Cast Base Metal*	165	D5120	Complete Lower Denture	140
D2782	Crown, ¾ Cast Noble Metal*	165	D5130	Immed. Complete Upper Denture	140
D2790	Crown, Full Cast Hi Noble Metal*	155	D5140	Immed. Complete Lower Denture	140
D2791	Crown, Full Cast Base Metal*	155	D5211	Upper Part. Denture, Resin Base	170
D2792	Crown, Full Cast Noble Metal*	155	D5212	Lower Part. Denture, Resin Base	170
D2794	Crown, Titanium*	155	D5213	Upper Part. Denture, Metal Frame	140
			D5214	Lower Part. Denture, Metal Frame	140
			D5410	Adjust Complete Upper Denture	15
			D5411	Adjust Complete Lower Denture	15
			D5421	Adjust Partial Denture, Upper	15

Code	Description	Member Copayment	Code	Description	Member Copayment
D5422	Adjust Partial Denture, Lower	15	D7320	Alveoplasty w/o Ext., Per Quad.	25
D5510	Repair Broken Denture Base	15	D7321	Alveoplasty w/o Ext., 1-3 Teeth	25
D5520	Replace Broken/Missing Tooth	15	D7960	Frenectomy	16
D5610	Repair Resin Denture Base	15	D7971	Excision Periocoronary Gingiva	40
D5620	Repair Cast Framework	15		Adjunctive Services	
D5630	Repair/Replace Broken Clasp	10	D9110	Emerg. Palliative Treat., Minor	12
D5640	Replace Broken Tooth, Per Tooth	10	D9215	Local Anesthesia	0
D5650	Add Tooth to Partial Denture	10	D9230	Analgesia, Nitrous Oxide, 1 st 15 Min.	35
D5660	Add Clasp to Partial Denture	10	D9230	Analgesia, Nitrous Oxide, Add. 15 Min.	15
D5710	Rebase Complete Upper Denture	65	D9310	Consultation	50
D5711	Rebase Complete Lower Denture	65	D9430	Office Visit, During Reg. Hrs., No Treat	0
D5720	Rebase Upper Partial Denture	65	D9440	Office visit, After Reg. Hrs.	20
D5721	Rebase Lower Partial Denture	65	D9630	Other Drugs and/or Medicaments	15
D5730	Reline Upper Denture, Chairside	25	D9951	Occlusal Adjustment, Limited	15
D5731	Reline Lower Denture, Chairside	25	D9952	Occlusal Adjustment, Complete	20
D5740	Reline Upper Part. Dent., Chairside	25	D9999	Broken Appt., Less Than 24 Hr. Notice	20
D5741	Reline Lower Part. Dent., Chairside	25	D9999	Office Visit, Per Visit	0
D5750	Reline Upper Denture, Lab.	35		Orthodontics	
D5751	Reline Lower Denture, Lab.	35		Removable Appliance Therapy	350
D5760	Reline Upper Part. Denture, Lab.	35		(to age 18)	
D5761	Reline Lower Part. Denture, Lab.	35		Fixed Appliance Therapy	350
D5820	Interim Partial Denture, Upper	15		(to age 18)	
D5821	Interim Partial Denture, Lower	15		Start-up Fees	175
D5850	Tissue Conditioning, Maxillary	10		(X-rays, Tracings, Case Studies, Study Models)	
D5851	Tissue Conditioning, Mandibular	10		Class I Malocclusion, Both Arches	2200
	Fixed Prosthodontics			Class I Malocclusion, 1 Arch	1100
D6210	Pontic, Cast Hi Noble Metal*	145		Class II Malocclusion, Both Arches	2300
D6211	Pontic, Cast Base Metal*	145		Class II Malocclusion, 1 Arch	1150
D6212	Pontic, Cast Noble Metal*	145		Class III Malocclusion, Both Arches	2300
D6214	Pontic, Titanium*	145		Class III Malocclusion, 1 Arch	1150
D6240	Pontic, Porc./Hi Noble Metal*	145		Post Treat. Stabilization, Child	300
D6241	Pontic, Porc./Base Metal*	145		Post Treat. Stabilization, Adult	350
D6242	Pontic, Porc./Noble Metal*	145			
D6750	Crown, Porc./Hi Noble Metal*	140		* Base metal is the benefit.	
D6751	Crown, Porc./Base Metal*	140		Noble, 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.	
D6752	Crown, Porc./Noble Metal*	140			
D6780	Crown, ¾ Cast Hi Noble Metal*	90		Resin, porcelain and any resin to metal or porcelain to metal crowns and pontics are a benefit on anterior and bicuspid teeth only.	
D6781	Crown, ¾ Cast Base Metal*	90			
D6782	Crown, ¾ Cast Noble Metal*	90			
D6790	Crown, Cast Hi Noble Metal*	155			
D6791	Crown, Cast Base Metal*	155			
D6792	Crown, Cast Noble Metal*	155			
D6794	Crown, Titanium*	155			
D6930	Recement Fixed Partial Denture	0			
D6970	Cast Post & Core, In Addition*	50			
D6971	Cast Post & Core, As Part Of*	50			
D6972	Prefab. Post & Core	50			
D6973	Core Buildup, Inc. Pins	75			
	Oral Surgery Services				
D7140	Extraction, Erupt. Tooth or Root	5			
D7210	Surgical Extraction, Erupted Tooth	15			
D7220	Extraction, Soft Tissue Impaction	32			
D7230	Extraction, Partial Bony Impaction	50			
D7240	Extraction, Full Bony Impaction	75			
D7241	Extraction, Full Bony, Unusual	85			
D7250	Surgical Extraction, Residual Roots	30			
D7285	Biopsy of Oral Tissue, Hard	5			
D7286	Biopsy of Oral Tissue, Soft	3			
D7310	Alveoplasty with Ext., Per Quad.	25			
D7311	Alveoplasty with Ext., 1-3 Teeth	25			
				Member Services	
				(888) 703-6999	
				8:00 a.m – 5:00 p.m.	

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 18th birth date.
4. Sealants are covered only on the first and second permanent molars and up to the 14th 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