LIBERTY FL Family Plus Dental HMO Plan

Individual Out-of-Pocket Maximum: $350 - Calendar Year (applies to Pediatric only)
Family Out-of-Pocket Maximum: $700 - Calendar Year (applies to Pediatric only)

The following is a complete list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. Members must visit a contracted dental office to utilize covered benefits. The Member's dental office will initiate a treatment plan or recommend the Member to see a specialist if the services are dentally necessary and outside the scope of general dentistry.

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Diagnostic Services			
D0120	Periodic oral evaluation	$0.00	$0.00	2 of (D0120, D0150, D0180) every 12 months
D0150	Comprehensive oral evaluation	$0.00	$0.00	
D0180	Comprehensive periodontal evaluation	$0.00	$0.00	
D0140	Limited oral evaluation	$0.00	$0.00	1 of (D0140, D0160, D0171) every 12 months
D0160	Oral evaluation, problem focused	$0.00	$0.00	
D0171	Re-evaluation, post operative office visit	$0.00	$0.00	
D0145	Oral evaluation under age 3	$0.00	NPB	
D0210	Intraoral, complete series of radiographic images	$0.00	$10.00	1 of (D0210, D0330) every 36 months
D0330	Panoramic radiographic image	$0.00	$10.00	
D0220	Intraoral, periapical, first radiographic image	$0.00	$0.00	
D0230	Intraoral, periapical, each add 'l radiographic image	$0.00	$0.00	
D0240	Intraoral, occlusal radiographic image	$0.00	$5.00	
D0270	Bitewing, single radiographic image	$0.00	$0.00	1 of (D0270-D0277) every 6 months
D0272	Bitewings, two radiographic images	$0.00	$0.00	
D0273	Bitewings, three radiographic images	$0.00	$0.00	
D0274	Bitewings, four radiographic images	$0.00	$0.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	$0.00	$5.00	
D0425	Caries susceptibility tests	$0.00	NPB	
D0460	Pulp vitality tests	$0.00	$0.00	
D0470	Diagnostic casts	$0.00	$0.00	
D0999	Unspecified diagnostic procedure, by report	$20.00	$5.00	office visit, per visit (in addition to other services)
	Preventive Services			
D1110	Prophylaxis, adult	$0.00	$10.00	4 of (D1110, D1120, D4346, D4910) every 12 months
D1120	Prophylaxis, child	$0.00	NPB	
D1206	Topical application of fluoride varnish	$0.00	NPB	2 of (D1206, D1208) every 12 months
D1208	Topical application of fluoride, excluding varnish	$0.00	$0.00	
D1351	Sealant, per tooth	$0.00	NPB	1 of (D1351, D1352) per tooth every 36 months, 1st and 2nd permanent molars up to age 14
D1352	Preventive resin restoration, permanent tooth	$0.00	NPB	
D1353	Sealant repair, per tooth	$0.00	NPB	1 (D1353) per tooth every 36 months, 1st and 2nd permanent molars up to age 14
D1510	Space maintainer, fixed, unilateral	$0.00	$40.00	2 of (D1510-D1527) every 12 months, 4 units per lifetime
D1516	Space maintainer, fixed, bilateral, maxillary	$0.00	$40.00	
D1517	Space maintainer, fixed, bilateral, mandibular	$0.00	$40.00	
D1520	Space maintainer, removable, unilateral	$0.00	$40.00	
D1526	Space maintainer, removable, bilateral, maxillary	$0.00	$40.00	
D1527	Space maintainer, removable, bilateral, mandibular	$0.00	$40.00	
D1550	Re-cement or re-bond space maintainer	$0.00	$2.50	
D1575	Distal shoe space maintainer, fixed, unilateral	$0.00	$40.00	
	Restorative Services			
D2140	Amalgam, one surface, primary or permanent	$40.00	$12.50	1 of (D2140-D2394) per tooth per surface every 24 months, if replacement restoration is less than 24 months by the same dental office or provider it is not chargeable to the plan or member
D2150	Amalgam, two surfaces, primary or permanent	$45.00	$17.50	
D2160	Amalgam, three surfaces, primary or permanent	$50.00	$25.00	
D2161	Amalgam, four or more surfaces, primary or permanent	$60.00	$27.50	
D2330	Resin-based composite, one surface, anterior	$50.00	$32.50	
D2331	Resin-based composite, two surfaces, anterior	$60.00	$37.50	
D2332	Resin-based composite, three surfaces, anterior	$70.00	$42.50	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$80.00	$57.50	
D2391	Resin-based composite, one surface, posterior	$75.00	$37.50	
D2392	Resin-based composite, two surfaces, posterior	$55.00	$42.50	
D2393	Resin-based composite, three surfaces, posterior	$95.00	$57.50	
D2394	Resin-based composite, four or more surfaces, posterior	$105.00	$60.00	

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Major Restorative Services			
***GUIDELINES for Inlays, Onlays, and Single Crowns:** The Contracted Dentist may charge no more than $325.00 (for the total of the applicable charges in #1-4 below) in addition to the listed Copayment. **1.** When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit. **2.** Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee $150.00 per unit. **3.** For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of $75.00 per unit. **4.** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades.			
D2510	Inlay, metallic, one surface	$225.00	$127.50	1 of (D2510-D2794, D6058-D6077, D6114-D6117, D6210-D6792) per tooth every 60 months, age 12 and over
D2520	Inlay, metallic, two surfaces	$365.00	$132.50	
D2530	Inlay, metallic, three or more surfaces	$325.00	$137.50	
D2542	Onlay, metallic, two surfaces	$345.00	$132.50	
D2543	Onlay, metallic, three surfaces	$350.00	$142.50	
D2544	Onlay, metallic, four or more surfaces	$350.00	$147.50	
D2740	Crown, porcelain/ceramic*	$350.00	$237.50	
D2750	Crown, porcelain fused to high noble metal*	$350.00	$232.50	
D2751	Crown, porcelain fused to predominantly base metal	$350.00	$195.00	
D2752	Crown, porcelain fused to noble metal*	$350.00	$222.50	
D2780	Crown, ¾ cast high noble metal*	$350.00	$232.50	
D2781	Crown, ¾ cast predominantly base metal	$350.00	$195.00	
D2783	Crown, ¾ porcelain/ceramic*	$350.00	$237.50	
D2790	Crown, full cast high noble metal*	$350.00	$232.50	
D2791	Crown, full cast predominantly base metal	$350.00	$190.00	
D2792	Crown, full cast noble metal*	$350.00	$222.50	
D2794	Crown, titanium*	$350.00	$232.50	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$45.00	$7.50	1 of (D2910, D2920) per tooth every 6 months, if provided within 12 months of placement by the same dentist is included at no additional cost to the Enrollee or Plan
D2920	Re-cement or re-bond crown	$50.00	$7.50	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$100.00	NPB	1 of (D2929-D2931) per tooth per lifetime up to age 15
D2930	Prefabricated stainless steel crown, primary tooth	$75.00	NPB	
D2931	Prefabricated stainless steel crown, permanent tooth	$100.00	NPB	
D2940	Protective restoration	$60.00	NPB	
D2950	Core buildup, including any pins when required	$95.00	$42.50	1 (D2950) per tooth every 60 months, age 12 and over
D2951	Pin retention, per tooth, in addition to restoration	$30.00	$15.00	
D2954	Prefabricated post and core in addition to crown	$115.00	$47.50	1 (D2954) per tooth every 60 months, age 12 and over
D2980	Crown repair necessitated by restorative material failure	$105.00	$37.50	
	Endodontic Services			
D3110	Pulp cap, direct (excluding final restoration)	$40.00	$10.00	
D3120	Pulp cap, indirect (excluding final restoration)	$40.00	$10.00	
D3220	Therapeutic pulpotomy (excluding final restoration)	$75.00	$12.50	1 (D3220) per tooth per lifetime
D3221	Pulpal debridement, primary and permanent teeth	$70.00	$40.00	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$70.00	$40.00	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$80.00	$40.00	1 of (D3230, D3240) per tooth per lifetime
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$80.00	$40.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$270.00	$110.00	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$320.00	$175.00	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$350.00	$212.50	
D3346	Retreatment of previous root canal therapy, anterior	$350.00	$250.00	
D3347	Retreatment of previous root canal therapy, premolar	$350.00	$300.00	
D3348	Retreatment of previous root canal therapy, molar	$350.00	$350.00	
D3351	Apexification/recalcification, initial visit	$105.00	NPB	
D3352	Apexification/recalcification, interim medication replacement	$110.00	NPB	
D3353	Apexification/recalcification, final visit	$230.00	NPB	
D3410	Apicoectomy, anterior	$275.00	$232.50	
D3421	Apicoectomy, premolar (first root)	$285.00	$262.50	
D3425	Apicoectomy, molar (first root)	$305.00	$287.50	
D3426	Apicoectomy, (each additional root)	$115.00	$55.00	
D3430	Retrograde filling, per root	$85.00	$30.00	
D3450	Root amputation, per root	$145.00	$155.00	
D3920	Hemisection, not including root canal therapy	$105.00	$45.00	
	Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$205.00	$127.50	1 of (D4210-D4275, D4283-D4285) per site/quad every 24 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$125.00	$72.50	

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Periodontal Services (continued)			
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$125.00	$72.50	1 of (D4210-D4275, D4283-D4285) per site/quad every 24 months
D4240	Gingival flap procedure, four or more teeth per quadrant	$225.00	$172.50	
D4241	Gingival flap procedure, one to three teeth per quadrant	$225.00	$172.50	
D4260	Osseous surgery, four or more teeth per quadrant	$350.00	$322.50	
D4261	Osseous surgery, one to three teeth per quadrant	$200.00	$255.00	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$245.00	$142.50	
D4270	Pedicle soft tissue graft procedure	$245.00	$142.50	
D4273	Autogenous connective tissue graft procedure, first tooth	$265.00	$162.50	
D4275	Non-autogenous connective tissue graft, first tooth	$245.00	$142.50	
D4277	Free soft tissue graft, first tooth	$200.00	$112.50	1 of (D4277-D4278) per site/quad every 24 months
D4278	Free soft tissue graft, each additional tooth	$200.00	$112.50	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$265.00	$162.50	1 of (D4210-D4275, D4283-D4285) per site/quad every 24 months
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$245.00	$142.50	
D4249	Clinical crown lengthening, hard tissue	$175.00	$137.50	1 (D4249) per tooth per lifetime
GUIDELINE:				
No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.				
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$120.00	$60.00	1 of (D4341, D4342) per site/quad every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$90.00	$32.50	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0.00	$10.00	4 of (D1110, D1120, D4346, D4910) every 12 months
D4355	Full mouth debridement	$60.00	$37.50	1 (D4355) per lifetime
D4910	Periodontal maintenance	$80.00	$40.00	4 of (D1110, D1120, D4346, D4910) every 12 months
	Removable Prosthodontic Services			
D5110	Complete denture, maxillary	$350.00	$252.50	1 of (D5110-D5224, D5282, D5823) per arch every 60 months, D5213-D5214, D5223-D5224 age 12 and over
D5120	Complete denture, mandibular	$350.00	$252.50	
D5130	Immediate denture, maxillary	$350.00	$252.50	
D5140	Immediate denture, mandibular	$350.00	$252.50	
D5211	Maxillary partial denture, resin base	$350.00	$250.00	
D5212	Mandibular partial denture, resin base	$350.00	$300.00	
D5213	Maxillary partial denture, cast metal, resin base	$350.00	$300.00	
D5214	Mandibular partial denture, cast metal, resin base	$350.00	$300.00	
D5221	Immediate maxillary partial denture, resin base	$350.00	$250.00	
D5222	Immediate mandibular partial denture, resin base	$350.00	$300.00	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$350.00	$300.00	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$350.00	$300.00	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$305.00	NPB	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$305.00	NPB	
D5410	Adjust complete denture, maxillary	$40.00	$10.00	1 of (D5410-D5422) per arch every 12 months
D5411	Adjust complete denture, mandibular	$40.00	$10.00	
D5421	Adjust partial denture, maxillary	$40.00	$10.00	
D5422	Adjust partial denture, mandibular	$40.00	$10.00	
D5511	Repair broken complete denture base, mandibular	$80.00	$22.50	
D5512	Repair broken complete denture base, maxillary	$80.00	$22.50	
D5520	Replace missing or broken teeth, complete denture	$70.00	$17.50	
D5611	Repair resin partial denture base, mandibular	$75.00	$27.50	
D5612	Repair resin partial denture base, maxillary	$75.00	$27.50	
D5621	Repair cast partial framework, mandibular	$105.00	$27.50	
D5622	Repair cast partial framework, maxillary	$105.00	$27.50	
D5630	Repair or replace broken retentive clasping, per tooth	$85.00	$32.50	
D5640	Replace broken teeth, per tooth	$95.00	$20.00	
D5650	Add tooth to existing partial denture	$80.00	$27.50	
D5660	Add clasp to existing partial denture, per tooth	$100.00	$35.00	
D5710	Rebase complete maxillary denture	$205.00	$90.00	1 of (D5710-D5761) per arch every 36 months
D5711	Rebase complete mandibular denture	$205.00	$90.00	
D5720	Rebase maxillary partial denture	$205.00	$90.00	
D5721	Rebase mandibular partial denture	$215.00	$90.00	
D5730	Reline complete maxillary denture, chairside	$125.00	$47.50	
D5731	Reline complete mandibular denture, chairside	$125.00	$47.50	
D5740	Reline maxillary partial denture, chairside	$125.00	$47.50	
D5741	Reline mandibular partial denture, chairside	$115.00	$47.50	
D5750	Reline complete maxillary denture, laboratory	$180.00	$75.00	
D5751	Reline complete mandibular denture, laboratory	$180.00	$75.00	

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Removable Prosthodontic Services (continued)			
D5760	Reline maxillary partial denture, laboratory	$180.00	$75.00	1 of (D5710-D5761) per arch every 36 months
D5761	Reline mandibular partial denture, laboratory	$170.00	$75.00	
D5850	Tissue conditioning, maxillary	$70.00	$20.00	
D5851	Tissue conditioning, mandibular	$80.00	$20.00	
	Implant Services			
***GUIDELINES for Implant Abutments:**				
The Contracted Dentist may charge no more than $325.00 (for the total of the applicable charges in #1-4 below) in addition to the listed Copayment.				
1. When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit.				
2. Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee $150.00 per unit.				
3. For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of $75.00 per unit.				
4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades.				
D6010	Surgical placement of implant body, endosteal	$350.00	NPB	1 of (D6010, D6040) per tooth per lifetime
D6040	Surgical placement: eposteal implant	$350.00	NPB	
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	$350.00	NPB	1 (D6012) per tooth per lifetime
D6050	Surgical placement: transosteal implant	$350.00	NPB	
D6055	Connecting bar, implant supported or abutment supported	$350.00	NPB	
D6056	Prefabricated abutment, includes modification and placement	$350.00	NPB	
D6057	Custom fabricated abutment, includes placement	$350.00	NPB	
D6058	Abutment supported porcelain/ceramic crown*	$350.00	NPB	1 of (D2510-D2794, D6058-D6077, D6114-D6117, D6210-D6792) per tooth every 60 months, age 16 and over
D6059	Abutment supported porcelain fused to high noble crown*	$350.00	NPB	
D6060	Abutment supported porcelain fused to base metal crown	$350.00	NPB	
D6061	Abutment supported porcelain/noble metal crown*	$350.00	NPB	
D6062	Abutment supported cast metal crown, high noble*	$350.00	NPB	
D6063	Abutment supported cast metal crown, base metal	$350.00	NPB	
D6064	Abutment supported cast metal crown, noble metal*	$350.00	NPB	
D6065	Implant supported porcelain/ceramic crown*	$350.00	NPB	
D6066	Implant supported porcelain/metal crown*	$350.00	NPB	
D6067	Implant supported metal crown	$350.00	NPB	
D6068	Abutment supported retainer, porcelain/ceramic FPD*	$350.00	NPB	
D6069	Abutment supported retainer, metal FPD, high noble*	$350.00	NPB	
D6070	Abutment supported retainer, porcelain /metal FPD, base metal	$350.00	NPB	
D6071	Abutment supported retainer, porcelain /metal FPD, noble*	$350.00	NPB	
D6072	Abutment supported retainer, cast metal FPD, high noble*	$350.00	NPB	
D6073	Abutment supported retainer, cast metal FPD, base metal	$350.00	NPB	
D6074	Abutment supported retainer, cast metal FPD, noble*	$350.00	NPB	
D6075	Implant supported retainer for ceramic FPD*	$350.00	NPB	
D6076	Implant supported retainer for porcelain /metal FPD*	$350.00	NPB	
D6077	Implant supported retainer for cast metal FPD	$350.00	NPB	
D6080	Implant maintenance procedures	$50.00	NPB	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$20.00	NPB	1 of (D6081) per implant every 12 months
D6090	Repair implant prosthesis	$80.00	NPB	
D6091	Replacement of semi-precision or precision attachment	$20.00	NPB	
D6095	Repair implant abutment, by report	$230.00	NPB	
D6100	Implant removal, by report	$180.00	NPB	
D6110	Implant/abutment supported removable denture, maxillary	$350.00	NPB	
D6111	Implant/abutment supported removable denture, mandibular	$350.00	NPB	
D6112	Implant/abutment supported removable denture, partial, maxillary	$350.00	NPB	
D6113	Implant/abutment supported removable denture, partial, mandibular	$350.00	NPB	
D6114	Implant/abutment supported fixed denture, maxillary	$350.00	NPB	1 of (D2510-D2794, D6058-D6077, D6114-D6117, D6210-D6792) per tooth every 60 months, age 16 and over
D6115	Implant/abutment supported fixed denture, mandibular	$350.00	NPB	
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350.00	NPB	
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350.00	NPB	
	Fixed Prosthodontic Services			
***GUIDELINES for Bridges:**				
The Contracted Dentist may charge no more than $325.00 (for the total of the applicable charges in #1-4 below) in addition to the listed Copayment.				
1. When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit.				
2. Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee $150.00 per unit.				
3. For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of $75.00 per unit.				
4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades.				
D6210	Pontic, cast high noble metal*	$350.00	$212.50	1 of (D2510-D2794, D6058-D6077, D6114-D6117, D6210-D6792) per tooth every 60 months, age 16 and over
D6211	Pontic, cast predominantly base metal	$350.00	$162.50	
D6212	Pontic, cast noble metal*	$350.00	$212.50	
D6214	Pontic, titanium*	$350.00	NPB	
D6240	Pontic, porcelain fused to high noble metal*	$350.00	$212.50	

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Fixed Prosthodontic Services (continued)			
D6241	Pontic, porcelain fused to predominantly base metal	$380.00	$162.50	1 of (D2510-D2794, D6058-D6077, D6114-D6117, D6210-D6792) per tooth every 60 months, age 16 and over
D6242	Pontic, porcelain fused to noble metal*	$400.00	$212.50	
D6245	Pontic, porcelain/ceramic*	$350.00	$247.50	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$210.00	NPB	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis*	$210.00	NPB	
D6549	Resin retainer, for resin bonded fixed prosthesis	$210.00	NPB	
D6740	Retainer crown, porcelain/ceramic*	$350.00	$247.50	
D6750	Retainer crown, porcelain fused to high noble metal*	$350.00	$212.50	
D6751	Retainer crown, porcelain fused to predominantly base metal	$350.00	$162.50	
D6752	Retainer crown, porcelain fused to noble metal*	$350.00	$212.50	
D6780	Retainer crown, ¾ cast high noble metal*	$350.00	$212.50	
D6781	Retainer crown, ¾ cast predominantly base metal	$350.00	$162.50	
D6782	Retainer crown, ¾ cast noble metal*	$350.00	$212.50	
D6783	Retainer crown, ¾ porcelain/ceramic*	$350.00	$247.50	
D6790	Retainer crown, full cast high noble metal*	$350.00	$232.50	
D6791	Retainer crown, full cast predominantly base metal	$350.00	$205.00	
D6792	Retainer crown, full cast noble metal*	$350.00	$232.50	
D6930	Re-cement or re-bond fixed partial denture	$60.00	$15.00	1 (D6930) per tooth every 6 months, if provided within 12 months of placement by the same dentist is included at no additional cost to the Enrollee or Plan
D6980	Fixed partial denture repair, restorative material failure	$140.00	$37.50	
	Oral & Maxillofacial Services			
D7140	Extraction, erupted tooth or exposed root	$130.00	$22.50	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$160.00	$35.00	Removal of impacted third molars in Enrollees under 19 is not covered unless specific documentation is provided that substantiates the need for removal and is approved the Plan
D7220	Removal of impacted tooth, soft tissue	$160.00	$50.00	
D7230	Removal of impacted tooth, partially bony	$200.00	$95.00	
D7240	Removal of impacted tooth, completely bony	$250.00	$105.00	
D7241	Removal impacted tooth, complete bony, complication	$250.00	$115.00	
D7250	Removal of residual tooth roots (cutting procedure)	$200.00	$50.00	
D7251	Coronectomy, intentional partial tooth removal	$35.00	$115.00	
D7270	Tooth reimplantation and/or stabilization, accident	$135.00	NPB	
D7280	Exposure of an unerupted tooth	$105.00	NPB	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$75.00	$75.00	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$95.00	$75.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$95.00	$100.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$145.00	$100.00	
D7471	Removal of lateral exostosis, maxilla or mandible	$295.00	$75.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	$95.00	$17.50	
D7910	Suture of recent small wounds up to 5 cm	$75.00	NPB	
D7921	Collection and application of autologous blood concentrate product	$230.00	NPB	
D7971	Excision of pericoronal gingiva	$55.00	NPB	
	Orthodontic Services			
All copayments paid by the enrollee, including orthodontic copayments, apply towards the annual Out of Pocket Maximum.				
D0340	2D cephalometric radiographic image, measurement and analysis	$94.00	NPB	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$40.00	NPB	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	$61.00	NPB	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350.00	NPB	
D8090	Comprehensive orthodontic treatment of the adult dentition	$350.00	NPB	
D8660	Pre-orthodontic treatment examination to monitor growth and development	$50.00	NPB	
D8670	Periodic orthodontic treatment visit	$30.00	NPB	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$100.00	NPB	
D8693	Re-cement or re-bond fixed retainer	$30.00	NPB	
	Adjunctive General Services			
D9110	Palliative (emergency) treatment, minor procedure	$0.00	$17.50	
GUIDELINE: Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.				
D9219	Evaluation for deep sedation or general anesthesia	$0.00	$0.00	

ADA Code	Description	Pediatric Copay[1]		Frequency Limitations
	Adjunctive General Services (continued)			
D9222	Deep sedation/general anesthesia, first 15 minutes	$60.00	$42.50	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$60.00	$42.50	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minutes	$70.00	$42.50	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$70.00	$42.50	
D9310	Consultation, other than requesting dentist	$0.00	$35.00	
D9440	Office visit, after regularly scheduled hours	$0.00	$20.00	
D9610	Therapeutic parenteral drug, single administration	$30.00	$15.00	
D9930	Treatment of complications, post surgical, unusual, by report	$30.00	$15.00	
D9944	Occlusal guard, hard appliance, full arch	$310.00	NPB	1 of (D9944-D9946) every 12 months, age 13 and over
D9945	Occlusal guard, soft appliance, full arch	$310.00	NPB	
D9946	Occlusal guard, hard appliance, partial arch	$310.00	NPB	
D9986	Missed appointment	$40.00	$15.00	
D9987	Cancelled appointment	$0.00	$0.00	

NPB Not Plan Benefit

[1]Pediatric Benefits – Apply to dependents through the age of 18

[2]Adult Benefits - Apply to Enrollees 19 and over

Out-of-Pocket Maximum means the maximum amount of copayments that a Pediatric Enrollee must pay for Benefits under this Program during a calendar year. If more than one Pediatric Enrollee is covered, the financial obligation for covered services is not more than the Family Out of-Pocket maximum. Once the amount paid by all Pediatric Enrollee(s) equals the annual Out-of-Pocket Maximum shown above, no further copayments are required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services.

Payment for services that are not covered under the Contract, are Optional, or are for upgraded treatment (such as precious or semi-precious metals and material upgrades) will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the Out-of-Pocket Maximum is met.

Record of payment for covered procedures should be kept by the Responsible Party. When the Out-of-Pocket Maximum has been reached; contact the Member Services Department at 877-877-1893 for instructions on how to submit proof that the Out-of-Pocket Maximum has been reached to LIBERTY Dental Plan.

Limitations:

1. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces performed within 24 months of the original restoration are included, and a separate fee is not chargeable to the Enrollee by a the provider.
2. The covered restorations includes all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
3. Core buildups can be considered for benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.
4. Replacement of crowns, inlays, onlays, fixed partial dentures, implant abutments and crowns, buildups, and posts and cores is covered only if the existing crown, inlay, onlay, fixed partial denture, implant abutment and crown, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented and cannot be made serviceable.
5. Fixed partial dentures ("bridges") for Enrollees under 16 years of age are not covered. (this includes pontics and retainer crowns D6200's and D6700's) Single Crowns, Inlays, Onlays, Crown buildups, and Posts and Cores for Enrollees under 12 years of age are not covered.
6. Onlays, inlays, crowns, fixed bridges, and posts and cores are covered only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, coverage is for that service.
7. Crowns, inlays, onlays, fixed partial dentures, implants, buildups, or posts and cores, begun within three months prior to the effective date of coverage are not eligible for coverage.
8. For reporting and benefit purposes, the completion date for crowns, onlays, inlays, and fixed partial dentures is the cementation date.
9. Pulpotomy is covered once per tooth per lifetime. Pulpotomy on permanent teeth not covered when root canal therapy is reported on the same tooth within 60 days.
10. Pulpal therapy is limited to primary teeth only and is payable once per primary tooth per lifetime
11. A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g. , crater) or surfaces involved. Another site on the same tooth is included to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.
12. Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or intrabony defects. It is not covered when provided to obtain root coverage, or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g. apicoectomy or hemisection.
13. Periodontal maintenance is only covered when performed following active periodontal treatment.
14. An oral evaluation reported in addition to periodontal maintenance will be covered as a separate procedure subject to the policy and limitations applicable to oral evaluations.
15. Services or treatment for the provision of an initial placement of a removable prosthetic appliance replacing a natural tooth or tooth missing within three months prior to the Effective Date of Coverage are not covered. This includes teeth lost or missing due to a congenital defect.
16. Removable cast base partial dentures (D5213 and D5214) for Enrollees under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by LIBERTY Dental Plan.
17. For reporting and benefit purposes, the completion date is the insertion date for removable prosthodontic appliances immediate dentures, however, the dentist who fabricated the dentures may be reimbursed for the dentures after insertion if another dentist, typically an oral surgeon, inserted the dentures.
18. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are included at no additional cost to the Enrollee when made by the same dentist.
19. With the exception of a new immediate denture, relining or rebasing is covered at no additional cost to the Enrollee within six months of a denture's initial delivery.
20. Coverage for a denture made with precious metals is based on the allowance for a conventional denture.
21. A fixed partial denture and removable partial denture are not covered benefits in the same arch is for a removable partial denture to replace all missing teeth in the arch.
22. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
23. Replacement of removable prostheses is covered only if the existing removable prostheses was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing removable prostheses cannot be made serviceable.
24. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.
25. Removable prostheses initiated prior to the effective date of coverage or inserted after the cancellation date of coverage are not eligible for coverage.
26. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are included to the fee for reimplantation and/or stabilization.
27. Routine postoperative care such as suture removal is included to the fee for the surgery.
28. The removal of impacted teeth is covered based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, coverage will be based on the allowance for the lesser level.
29. Removal of impacted third molars in Enrollees under 19 is not covered unless specific documentation is provided that substantiates the need for removal and is approved the Plan
30. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) and when rendered by a dentist or other professional licensed dentist and approved to provide anesthesia in the state where the service is rendered.
31. Deep sedation/general anesthesia and intravenous conscious sedation are covered only by report when determined to be medically or dentally necessary for documented handicapped or uncontrollable Enrollees or justifiable medical or dental conditions.
32. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted.
33. Deep sedation/general anesthesia and intravenous conscious sedation submitted without a report will be denied as a non-covered benefit.
34. For palliative (emergency) treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention.

Limitations Continued:

35 In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the Enrollee's problem. If the only service provided is to evaluate the Enrollee and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.

36 Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.

37 Consultations reported for a non-covered benefit, such as Temporomandibular Joint Dysfunction (TMJD), are not covered.

38 After hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the Enrollee in an emergency situation.

39 Therapeutic drug injections are only covered in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

40 Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.

41 Occlusal guards are covered by report for Enrollee 13 years of age or older when the purpose of the occlusal guard is the treatment of bruxism. Occlusal guards are limited to one per 12 consecutive month period.

42 Services are limited to medically necessary orthodontics when provided by a Contract Dentist and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this Plan only when medically necessary as evidenced by a severe handicapping malocclusion for Enrollees under the age of 19 and shall be prior authorized by the Plan.

43 Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

44 The automatic qualifying conditions are:

- a Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
- b A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
- c A crossbite of individual anterior teeth causing destruction of soft tissue,
- d Severe traumatic deviation.

45 The following documentation must be submitted to the Plan with the request for prior authorization of services by the Contract Dentist:

- a ADA 2006 or newer claim form with service code(s) requested;
- b Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
- c Cephalometric radiographic image or panoramic radiographic image;
- d HLD score sheet completed and signed by the Orthodontist; and
- e Treatment plan.

46 The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.

47 Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

48 Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.

49 Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

50 All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

51 When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the Plan will make an allowance for the cost of a standard orthodontic treatment.

52 Repair and replacement of an orthodontic appliance inserted under the Plan that has been damaged, lost, stolen, or misplaced is not a covered service.

53 Procedure D8080 Comprehensive orthodontic treatment of the adolescent dentition The allowances for comprehensive orthodontic treatment procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted. Procedure D8090 Comprehensive orthodontic treatment of the adult dentition The allowances for comprehensive orthodontic treatment procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is

54 Procedure D8660 Pre-orthodontic treatment visit. Under the Plan processing policies, this procedure is considered to be equivalent to procedure D0150, and is a benefit only for Enrollees with orthodontic coverage.

55 Procedure D8670 Periodic orthodontic treatment visit (as part of contract). Periodic treatment visits are part of, and included in the case fee for comprehensive orthodontic treatment.

56 Procedure D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)).

- a Under the Plan processing policies, the removal of orthodontic appliances is considered part of, and included in the comprehensive case fees for, orthodontic treatment when performed by the same dentist or dental office.
- b When this service is provided by a dentist or dental office other than the original treating orthodontist, please submit a narrative report.

57 Procedure D8693 Rebonding or recementing; and/or repair, as required, of fixed retainers.

- a The Plan considers this procedure to be included in the comprehensive case fee. A separate fee may not be charged to the Enrollee when submitted by the original treating dentist or dental office.
- b This procedure may be benefitted if performed by a dentist or dental office other than the original treating dentist or dental office. Fees for subsequent procedures attributable to lack of Enrollee compliance are the Enrollee's financial responsibility.

Exclusions:

1. Except as specifically provided, the following services, supplies, or charges are not covered:
2. Any dental service or treatment not specifically listed as a covered service.
3. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the Plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
4. Services or treatment provided by a member of the Enrollee's immediate family.
5. Those services submitted by a dentist which are for the same services performed on the same date for the same Enrollee by another dentist.
6. Those which are experimental or investigative (deemed unproven).
7. Those which are for any illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the member claims the benefits or compensation.
8. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
9. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
10. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
11. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
12. Those performed prior to the Enrollee's effective coverage date.
13. Those incurred after the termination date of the member's coverage unless otherwise indicated.
14. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the Enrollee by a Contract Dentist unless the dentist notifies the Enrollee of his/her liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records).
15. Those not meeting accepted standards of dental practice.
16. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
18. Those resulting from the Enrollee's failure to comply with professionally prescribed treatment.
19. Telephone consultations.
20. Any charges for failure to keep a scheduled appointment.
21. Duplicate and temporary devices, appliances, and services.
22. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
23. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
24. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
25. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
26. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
27. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
28. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
29. Adjunctive dental services as defined by applicable federal regulations.
30. Charges for copies of Enrollees' records, charts or x-rays, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or x-rays.
31. State or territorial taxes on dental services performed.
32. Medically necessary in the treatment of an otherwise covered medical (not dental) condition.
33. An integral part of the treatment of such medical condition.
34. Essential to the control of the primary medical condition.
35. Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).
36. These are medical services that may be covered under a medical policy even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
    - a Treatment for relief of Myofascial Pain Dysfunction Syndrome (MFPS) or Temporomandibular Joint Dysfunction (TMJD).
    - b Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
    - c Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventive procedure under this Plan.
    - d Treatment of total or complete ankyloglossia.
    - e Treatment of an extraoral abscess or intraoral abscess that extends beyond the dental alveolus.
    - f Treatment of cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.
    - g Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
    - h Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma).

LIBERTY DENTAL PLAN

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex.

LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

- Qualified interpreters, including sign language interpreters
- Written information in other languages and formats, including large print, audio, accessible electronic formats, etc.

If you need these services, please contact us at 1-877-877-1893.

If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

- **Phone:** 888-704-9833
- **TTY:** 800-735-2929
- **Fax:** 888-273-2718
- **Email:** compliance@libertydentalplan.com
- **Online:** https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

If you need help filing a grievance, LIBERTY's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LIBERTY's HIPAA Privacy Notice provides you with information about your rights and our legal duties and privacy practices with respect to Protected Health Information (PHI), including how we use and disclose your PHI. You can always request a written copy of our most current privacy notice from LIBERTY's Privacy Officer by calling 888.704.9833, or online at: www.libertydentalplan.com/HIPAA-Privacy-Notice.

LIBERTY DENTAL PLAN

Notice of Language Assistance

If you, or someone you're helping, has questions about LIBERTY Dental Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 877-1893.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de LIBERTY Dental Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (877) 877-1893. (Spanish)

如果您，或是您正在協助的對象，有關於 LIBERTY Dental Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 (877) 877-1893。(Chinese)

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về LIBERTY Dental Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (877) 877-1893. (Vietnamese)

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa LIBERTY Dental Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (877) 877-1893. (Tagalog)

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 LIBERTY Dental Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (877) 877-1893 로 전화하십시오. (Korean)

Si oumenm oswa yon moun w ap ede gen kesyon konsènan LIBERTY Dental Plan, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (877) 877-1893. (Haitian Creole)

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի LIBERTY Dental Plan մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք (877) 877-1893: (Armenian)

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу LIBERTY Dental Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (877) 877-1893. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص LIBERTY Dental Plan ، فلديك الحق في الحصول على المساعدة والمعلومات لضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 877-1893 (877) (Arabic)

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد LIBERTY Dental Plan ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 877-1893 (877) تماس حاصل نمایید (Farsi)

ご本人様、またはお客様の身の回りの方でも、LIBERTY Dental Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(877) 877-1893 までお電話ください。 (Japanese)

Notice of Language Assistance

ਜੇਕਰ ਤੁਹਾਡਾ, ਜਾਂ ਕੋਈ ਹੋਰ ਜਿਸਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ, ਉਸਦਾ LIBERTY Dental Plan (ਲਿਬਰਟੀ ਡੈਂਟਲ ਪਲੈਨ) ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੈ, ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪਾਉਣ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਅਨੁਵਾਦਕ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (877) 877-1893 'ਤੇ ਕਾਲ ਕਰੋ| (Punjabi)

បើសិនអ្នក ឬជនណាម្នាក់ដែលអ្នកជួយ មានសំណួរអំពី LIBERTY Dental Plan អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសាខ្មែរ ដោយឥតអស់ថ្លៃឡើយ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមហៅលេខ (877) 877-1893។ (Khmer)

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog LIBERTY Dental Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau (877) 877-1893. (Hmong)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o LIBERTY Dental Plan, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (877) 877-1893. (Portuguese)