LIBERTY Dental Plan Family Dental Select HMO
Small Business Market Place

Individual Out of Pocket Maximum: $350 per 2020-2021 Plan Year (applies to Pediatric only)
Family Out of Pocket Maximum: $700 per 2020-2021 Plan Year (applies to Pediatric only)
Individual Deductible: None - Family Deductible: None
Waiting Period: None Annual Benefit Limit: None
Office Visit Copay: No Charge Actuarial Value: 84.8%

✓ Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are medically necessary and outside the scope of general dentistry.

✓ Member Co-payments are payable to the dental office at the time services are rendered, and are subject to Out-of-Pocket Maximums. Pediatric benefits apply for Enrollees ages 0 to the age of 19. Adult benefits are not subject to Out-of-Pocket Maximums. There may be other costs incurred for optional, and non-covered services that do not apply toward Out-of-Pocket Maximums.

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations must be determined to be medically necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Diagnostic Services				
D0120	Periodic oral evaluation	no charge	no charge	1 (D0120) every 6 months per provider	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	no charge	no charge	1 (D0140) per patient per provider	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	no charge	not covered		
D0150	Comprehensive oral evaluation	no charge	no charge	1 (D0150) per patient per provider for initial evaluation	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	no charge	1 (D0160) per patient per provider	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	no charge	up to 6 of (D0170, D0171)in a 3 month period, no more than 12 in a 12 months	1 of (D0170, D0171) every 6 months
D0171	Re-evaluation, post operative office visit	no charge	no charge		
D0180	Comprehensive periodontal evaluation	no charge	no charge	only be billed as D0150	1 (D0180) every 6 months
D0190	Screening of a patient	not covered	no charge		
D0191	Assessment of a patient	not covered	no charge		
D0210	Intraoral, complete series of radiographic images	no charge	no charge	1 (D0210) every 36 months per provider	1 (D0210) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	no charge	20 of (D0220, D0230) PA's in a 12 month period by the same provider	20 of (D0220, D0230) PA's in a 12 month period by the same provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	no charge		
D0240	Intraoral, occlusal radiographic image	no charge	no charge	2 (D0240) every 6 months per provider	2 (D0240) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	no charge	1 (D0250) per date of service	1 (D0250) every 6 months
D0251	Extra-oral posterior dental radiographic image	no charge	not covered	1 (D0251) per date of service	1 (D0251) every 6 months
D0270	Bitewing, single radiographic image	no charge	no charge	1 (D0270) per date of service	1 (D0270) per date of service
D0272	Bitewings, two radiographic images	no charge	no charge	1 (D0272) every 6 months per provider	1 of (D0272-D0277) every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	no charge	downcode to D0270 and D0272	
D0274	Bitewings, four radiographic images	no charge	no charge	1 (D0274) every 6 months per provider, age 10 and over	
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	no charge	downcode to D0274	
D0310	Sialography	no charge	no charge		
D0320	TMJ arthrogram, including injection	no charge	no charge	3 (D0320) per date of service	3 (D0320) per date of service
D0322	Tomographic survey	no charge	no charge	2 (D0322) every 12 months per provider	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	no charge	no charge	1 (D0330) every 36 months per provider	1 (D0330) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	no charge	2 (D0340) every 12 months per provider	2 (D0340) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	no charge	4 (D0350) per date of service	4 (D0350) per date of service
D0351	3D photographic image	no charge	no charge		
D0431	Adjunctive pre-diagnostic test	not covered	no charge		
D0460	Pulp vitality tests	no charge	no charge		
D0470	Diagnostic casts	no charge	no charge	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent	1 (D0470) per provider
D0502	Other oral pathology procedures, by report	no charge	no charge		
D0601	Caries risk assessment and documentation, low risk	no charge	no charge		
D0602	Caries risk assessment and documentation, moderate risk	no charge	no charge		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Diagnostic Services (continued)				
D0603	Caries risk assessment and documentation, high risk	no charge	no charge		
D0999	Unspecified diagnostic procedure, by report	no charge	no charge		
	Preventive Services				
D1110	Prophylaxis, adult	no charge	no charge	1 of (D1110, D1120, D4346) every 6 months. Additional requests, beyond the stated frequency limitations, for prophylaxis procedures (D1110 and D1120) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.	1 of (D1110, D4346, D4910) every 6 months
D1120	Prophylaxis, child	no charge	not covered		
D1206	Topical application of fluoride varnish	no charge	no charge	1 of (D1206, D1208) every 6 months. Additional requests, beyond the stated frequency limitations, for fluoride procedures (D1206 and D1208) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	no charge	no charge		
D1310	Nutritional counseling for control of dental disease	no charge	no charge		
D1320	Tobacco counseling, control/prevention oral disease	no charge	not covered		
D1330	Oral hygiene instruction	no charge	no charge		
D1351	Sealant, per tooth	no charge	not covered	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars	
D1352	Preventive resin restoration, permanent tooth	no charge	not covered		
D1353	Sealant repair, per tooth	no charge	not covered	1 (D1353) every 36 months 1st, 2nd, 3rd molars	
D1354	Interim caries arresting medicament application, per tooth	no charge	no charge	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	no charge	not covered	1 of (D1510, D1520) per quadrant per	
D1516	Space maintainer, fixed, bilateral, maxillary	no charge	not covered	1 of (D1516, D1526) under age 18	
D1517	Space maintainer, fixed, bilateral, mandibular	no charge	not covered	1 of (D1517, D1527) under age 18	
D1520	Space maintainer, removable, unilateral, per quadrant	no charge	not covered	1 of (D1510, D1520) per quadrant per patient under age 18	
D1526	Space maintainer, removable, bilateral, maxillary	no charge	not covered	1 of (D1516, D1526) under age 18	
D1527	Space maintainer, removable, bilateral, mandibular	no charge	not covered	1 of (D1517, D1527) under age 18	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	no charge	not covered	1 of (D1551-D1553) per arch every 12 months under age 18	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	no charge	not covered		
D1553	Re-cement or re-bond unilateral space maintainer, mandibular	no charge	not covered		
D1556	Removal of fixed unilateral space maintainer, per quadrant	no charge	not covered		
D1557	Removal of fixed unilateral space maintainer, maxillary	no charge	not covered		
D1558	Removal of fixed unilateral space maintainer, mandibular	no charge	not covered		
D1575	Distal shoe space maintainer, fixed, per quadrant	no charge	not covered		
	Restorative Services				
D2140	Amalgam, one surface, primary or permanent	$25	$25	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2150	Amalgam, two surfaces, primary or permanent	$30	$30		
D2160	Amalgam, three surfaces, primary or permanent	$40	$40		
D2161	Amalgam, four or more surfaces, primary or permanent	$45	$45		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Restorative Services (continued)				
D2330	Resin-based composite, one surface, anterior	$30	$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2331	Resin-based composite, two surfaces, anterior	$45	$45		
D2332	Resin-based composite, three surfaces, anterior	$55	$55		
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$60	$60		
D2390	Resin-based composite crown, anterior	$50	$50	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months	1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	$30	$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2392	Resin-based composite, two surfaces, posterior	$40	$40		
D2393	Resin-based composite, three surfaces, posterior	$50	$50		
D2394	Resin-based composite, four or more surfaces, posterior	$70	$70		

***GUIDELINES for Single Crowns - Applies to Adult Dental Only**

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

1. Brand name restorations: (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.

2. Benefits for anterior and bicuspid teeth: Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.

3. Benefits for molar teeth: Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.

4. Base metal is the benefit: If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.

D2542	Onlay, metallic, two surfaces	not covered	$185		1 of (D2542-D2792, D6205-D6791) per tooth every 5 year period
D2543	Onlay, metallic, three surfaces	not covered	$200		
D2544	Onlay, metallic, four or more surfaces	not covered	$215		
D2642	Onlay, porcelain/ceramic, two surfaces*	not covered	$250		
D2643	Onlay, porcelain/ceramic, three surfaces*	not covered	$275		
D2644	Onlay, porcelain/ceramic, four or more surfaces*	not covered	$300		
D2662	Onlay, resin-based composite, two surfaces	not covered	$160		
D2663	Onlay, resin-based composite, three surfaces	not covered	$180		
D2664	Onlay, resin-based composite, four or more surfaces	not covered	$200		
D2710	Crown, resin-based composite (indirect)	$140	$140	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D2712	Crown, ¾ resin-based composite (indirect)	$190	$200		
D2720	Crown, resin with high noble metal*	not covered	$300		
D2721	Crown, resin with predominantly base metal*	$300	$300		
D2722	Crown, resin with noble metal*	not covered	$300		
D2740	Crown, porcelain/ceramic*	$300	$300		
D2750	Crown, porcelain fused to high noble metal*	not covered	$300		
D2751	Crown, porcelain fused to predominantly base metal*	$300	$300		
D2752	Crown, porcelain fused to noble metal*	not covered	$300		
D2780	Crown, ¾ cast high noble metal*	not covered	$300		
D2781	Crown, ¾ cast predominantly base metal	$300	$300		
D2782	Crown, ¾ cast noble metal*	not covered	$300		
D2783	Crown, ¾ porcelain/ceramic substrate*	$310	$310		
D2790	Crown, full cast high noble metal*	not covered	$300		
D2791	Crown, full cast predominantly base metal	$300	$300		
D2792	Crown, full cast noble metal*	not covered	$300		
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$25	$25	1 (D2910) per tooth every 12 months, per provider	

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Restorative Services (continued)				
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$25	$25		
D2920	Re-cement or re-bond crown	$25	$15	after 12 months of initial placement with same provider	
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	not covered		
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$95	not covered	1 of (D2929, D2930) per tooth every 12 months	
D2930	Prefabricated stainless steel crown, primary tooth	$65	not covered		
D2931	Prefabricated stainless steel crown, permanent tooth	$75	$75	1 (D2931) per tooth every 36 months	1 (D2931) per tooth every 36 months
D2932	Prefabricated resin crown	$75	not covered	primary - 1 of (D2932, D2933) per tooth every 12 months	
D2933	Prefabricated stainless steel crown with resin window	$80	not covered	permanent - 1 of (D2932, D2933) per tooth every 36 months	
D2940	Protective restoration	$25	$20	1 (D2940) per tooth every 6 months, per provider	1 (D2940) per tooth every 6 months, per provider
D2941	Interim therapeutic restoration, primary dentition	$30	not covered		
D2949	Restorative foundation for an indirect restoration	$45	not covered		
D2950	Core buildup, including any pins when required	$20	$20		
D2951	Pin retention, per tooth, in addition to restoration	$25	$20	1 (D2951) per tooth	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	1 (D2952) per tooth	
D2953	Each additional indirectly fabricated post, same tooth	$30	$30		
D2954	Prefabricated post and core in addition to crown	$90	$60	1 (D2954) per tooth	
D2955	Post removal	$60	not covered		
D2957	Each additional prefabricated post, same tooth	$35	$35		
D2971	Additional procedure to construct new crown, existing partial denture frame	$35	not covered		
D2980	Crown repair necessitated by restorative material failure	$50	$50	after 12 months of initial crown placement with same provider	
D2999	Unspecified restorative procedure, by report	$40	not covered		
	Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	$20	$20		
D3120	Pulp cap, indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration)	$40	$35	1 (D3220) per primary tooth	
D3221	Pulpal debridement, primary and permanent teeth	$40	$50	1 (D3221) per tooth	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$60	not covered	1 (D3222) per tooth	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$55	not covered	1 of (D3230, D3240) per tooth	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$55	not covered		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	$200	1 of (D3310, D3320, D3330) per tooth	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	$235		
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	$300		
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	$85		
D3333	Internal root repair of perforation defects	$80	not covered		
D3346	Retreatment of previous root canal therapy, anterior	$240	$245	1 of (D3346-D3348) after 12 months of initial treatment	1 of (D3346-D3348) per tooth per lifetime
D3347	Retreatment of previous root canal therapy, premolar	$295	$295		
D3348	Retreatment of previous root canal therapy, molar	$365	$365		
D3351	Apexification/recalcification, initial visit	$85	not covered	1 (D3351) per tooth	
D3352	Apexification/recalcification, interim medication replacement	$45	not covered	1 (D3352) per tooth	
D3410	Apicoectomy, anterior	$240	$240		
D3421	Apicoectomy, bicuspid (first root)	$250	$250		
D3425	Apicoectomy, molar (first root)	$275	$275		
D3426	Apicoectomy, (each additional root)	$110	$110		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Endodontic Services (continued)				
D3427	Periradicular surgery without apicoectomy	$160	not covered		
D3430	Retrograde filling, per root	$90	$90		
D3450	Root amputation, per root	not covered	$110		
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	not covered		
D3920	Hemisection, not including root canal therapy	not covered	$120		
D3950	Canal preparation and fitting of preformed dowel or post	not covered	$60		
D3999	Unspecified endodontic procedure, by report	$100	not covered		
	Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$150	$150	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	1 of (D4210-D4275) per site quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$50	$50		
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	$135		
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	$70		
D4249	Clinical crown lengthening, hard tissue	$165	$200		
D4260	Osseous surgery, four or more teeth per quadrant	$265	$265	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	
D4261	Osseous surgery, one to three teeth per quadrant	$140	$140		
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	$105		
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	not covered		
D4266	Guided tissue regeneration, resorbable barrier, per site	not covered	$145		
D4267	Guided tissue regeneration, non-resorbable barrier, per site	not covered	$175		
D4270	Pedicle soft tissue graft procedure	not covered	$155		
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	$220		
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	not covered	$190		
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	$55	$55	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over	1 of (D4341, D4342) per site quad, every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$30	$25		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$220	$220	1 of (D1110, D1120, D4346) every 6 months	1 of (D1110, D4346, D4910) every 6 months
D4355	Full mouth debridement	$40	$40		1 every 24 months
D4381	Localized delivery of antimicrobial agent/per tooth	$10	$10		
D4910	Periodontal maintenance	$30	$30	1 (D4910) every 3 months	1 of (D1110, D4346, D4910) every 6 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	$15	not covered	1 (D4920) per patient per provider, age 13 and over	
D4999	Unspecified periodontal procedure, by report	$350	not covered		
	Removable Prosthodontic Services				
D5110	Complete denture, maxillary	$300	$400	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	1 of (D5110-D5214, D5225-D5226, D5282, D5283) per arch every 5 year period.
D5120	Complete denture, mandibular	$300	$400		
D5130	Immediate denture, maxillary	$300	$400	1 (D5130) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	
D5140	Immediate denture, mandibular	$300	$400	1 (D5140) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Removable Prosthodontic Services (continued)				
D5211	Maxillary partial denture, resin base	$300	$325	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	1 of (D5110-D5214, D5225-D5226, D5282, D5283) per arch every 5 year period.
D5212	Mandibular partial denture, resin base	$300	$325		
D5213	Maxillary partial denture, cast metal, resin base	$335	$375		
D5214	Mandibular partial denture, cast metal, resin base	$335	$375		
D5221	Immediate maxillary partial denture, resin base	$275	not covered	1 of (D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	
D5222	Immediate mandibular partial denture, resin base	$275	not covered		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$330	not covered		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$330	not covered		
D5225	Maxillary partial denture, flexible base	not covered	$375		
D5226	Mandibular partial denture, flexible base	not covered	$375		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	$250		
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	$250		
D5410	Adjust complete denture, maxillary	$20	$20	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	$20	$20		
D5421	Adjust partial denture, maxillary	$20	$20		
D5422	Adjust partial denture, mandibular	$20	$20		
D5511	Repair broken complete denture base, mandibular	$40	$30	1 (D5511) per date of service per provider, 2 every 12 months per provider	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	$40	$30	1 (D5512) per date of service per provider, 2 every 12 months per provider	1 (D5512) per date of service per provider, 2 every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	$40	$30	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin denture base, mandibular	$40	$30	1 (D5611) per date of service per provider, 2 every 12 months per provider	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin denture base, maxillary	$40	$30	1 (D5612) per date of service per provider, 2 every 12 months per provider	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast framework, mandibular	$40	$35	1 (D5621) per date of service per provider, 2 every 12 months per provider	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast framework, maxillary	$40	$35	1 (D5622) per date of service per provider, 2 every 12 months per provider	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken clasp, per tooth	$50	$30	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	$35	$30	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	$35	$35	3 (D5650) per arch per provider per date of service, 1 per tooth	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	$60	$45	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	$195		1 (D5670) every 36 months
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	$195		1 (D5671) every 36 months
D5710	Rebase complete maxillary denture	not covered	$155		1 of (D5710, D5720,) every 12 months
D5711	Rebase complete mandibular denture	not covered	$155		1 of (D5711, D5721) every 12 months
D5720	Rebase maxillary partial denture	not covered	$150		1 of (D5710, D5720,) every 12 months

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Removable Prosthodontic Services (continued)				
D5721	Rebase mandibular partial denture	not covered	$150		1 of (D5711, D5721) every 12 months
D5730	Reline complete maxillary denture, chairside	$60	$80	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, chairside	$60	$80		
D5740	Reline maxillary partial denture, chairside	$60	$75		
D5741	Reline mandibular partial denture, chairside	$60	$75		
D5750	Reline complete maxillary denture, laboratory	$90	$120		
D5751	Reline complete mandibular denture, laboratory	$90	$120		
D5760	Reline maxillary partial denture, laboratory	$80	$110		
D5761	Reline mandibular partial denture, laboratory	$80	$110		
D5850	Tissue conditioning, maxillary	$30	$35	2 (D5850) every 36 months	1 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	$30	$35	2 (D5851) every 36 months	1 (D5851) every 36 months
D5862	Precision attachment, by report	$90	not covered		
D5863	Overdenture, complete, maxillary	$300	not covered	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	
D5864	Overdenture, partial, maxillary	$300	not covered		
D5865	Overdenture, complete, mandibular	$300	not covered		
D5866	Overdenture, partial, mandibular	$300	not covered		
D5899	Unspecified removable prosthodontic procedure, by report	$350	not covered		
	Maxillofacial Prosthetic Services				
D5911	Facial moulage (sectional)	$285	not covered		
D5912	Facial moulage (complete)	$350	not covered		
D5913	Nasal prosthesis	$350	not covered		
D5914	Auricular prosthesis	$350	not covered		
D5915	Orbital prosthesis	$350	not covered		
D5916	Ocular prosthesis	$350	not covered		
D5919	Facial prosthesis	$350	not covered		
D5922	Nasal septal prosthesis	$350	not covered		
D5923	Ocular prosthesis, interim	$350	not covered		
D5924	Cranial prosthesis	$350	not covered		
D5925	Facial augmentation implant prosthesis	$200	not covered		
D5926	Nasal prosthesis, replacement	$200	not covered		
D5927	Auricular prosthesis, replacement	$200	not covered		
D5928	Orbital prosthesis, replacement	$200	not covered		
D5929	Facial prosthesis, replacement	$200	not covered		
D5931	Obturator prosthesis, surgical	$350	not covered		
D5932	Obturator prosthesis, definitive	$350	not covered		
D5933	Obturator prosthesis, modification	$150	not covered	2 (D5933) every 12 months	
D5934	Mandibular resection prosthesis with guide flange	$350	not covered		
D5935	Mandibular resection prosthesis without guide flange	$350	not covered		
D5936	Obturator prosthesis, interim	$350	not covered		
D5937	Trismus appliance (not for TMD treatment)	$85	not covered		
D5951	Feeding aid	$135	not covered	under age 18	
D5952	Speech aid prosthesis, pediatric	$350	not covered	under age 18	
D5953	Speech aid prosthesis, adult	$350	not covered	age 18 and over	
D5954	Palatal augmentation prosthesis	$135	not covered		
D5955	Palatal lift prosthesis, definitive	$350	not covered		
D5958	Palatal lift prosthesis, interim	$350	not covered		
D5959	Palatal lift prosthesis, modification	$145	not covered	2 (D5959) every 12 months	
D5960	Speech aid prosthesis, modification	$145	not covered	2 (D5960) every 12 months	

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Maxillofacial Prosthetic Services (continued)				
D5982	Surgical stent	$70	not covered		
D5983	Radiation carrier	$55	not covered		
D5984	Radiation shield	$85	not covered		
D5985	Radiation cone locator	$135	not covered		
D5986	Fluoride gel carrier	$35	not covered		
D5987	Commissure splint	$85	not covered		
D5988	Surgical splint	$95	not covered		
D5991	Vesiculobullous disease medicament carrier	$70	not covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	not covered		
	Implant Services				
D6010	Surgical placement of implant body, endosteal	$350	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6011	Second stage implant surgery	$350	not covered		
D6013	Surgical placement of mini implant	$350	not covered		
D6040	Surgical placement: eposteal implant	$350	not covered		
D6050	Surgical placement: transosteal implant	$350	not covered		
D6052	Semi-precision attachment abutment	$350	not covered		
D6055	Connecting bar, implant supported or abutment supported	$350	not covered		
D6056	Prefabricated abutment, includes modification and placement	$135	not covered		
D6057	Custom fabricated abutment, includes placement	$180	not covered		
D6058	Abutment supported porcelain/ceramic crown	$320	not covered		
D6059	Abutment supported porcelain fused to high noble crown	$315	not covered		
D6060	Abutment supported porcelain fused to base metal crown	$295	not covered		
D6061	Abutment supported porcelain fused to noble metal crown	$300	not covered		
D6062	Abutment supported cast metal crown, high noble	$315	not covered		
D6063	Abutment supported cast metal crown, base metal	$300	not covered		
D6064	Abutment supported cast metal crown, noble metal	$315	not covered		
D6065	Implant supported porcelain/ceramic crown	$340	not covered		
D6066	Implant supported crown, porcelain fused to high noble alloys	$335	not covered		
D6067	Implant supported crown, high noble alloys	$340	not covered		
D6068	Abutment supported retainer, porcelain/ceramic FPD	$320	not covered		
D6069	Abutment supported retainer, metal FPD, high noble	$315	not covered		
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$290	not covered		
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$300	not covered		
D6072	Abutment supported retainer, cast metal FPD, high noble	$315	not covered		
D6073	Abutment supported retainer, cast metal FPD, base metal	$290	not covered		
D6074	Abutment supported retainer, cast metal FPD, noble	$320	not covered		
D6075	Implant supported retainer for ceramic FPD	$335	not covered		
D6076	Implant supported retainer for porcelain fused metal FPD	$330	not covered		
D6077	Implant supported retainer for cast metal FPD	$350	not covered		
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$30	not covered		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$30	not covered		
D6085	Provisional implant crown	$300	not covered		
D6090	Repair implant supported prosthesis, by report	$65	not covered		
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$40	not covered		
D6092	Re-cement or re-bond implant/abutment supported crown	$25	not covered		
D6093	Re-cement or re-bond implant/abutment supported FPD	$35	not covered		
D6094	Abutment supported crown, titanium, and titanium alloys	$295	not covered		
D6095	Repair implant abutment, by report	$65	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Implant Services (continued)				
D6096	Remove broken implant retaining screw	$60	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6100	Implant removal, by report	$110	not covered		
D6110	Implant/abutment supported removable denture, maxillary	$350	not covered		
D6111	Implant/abutment supported removable denture, mandibular	$350	not covered		
D6112	Implant/abutment supported removable denture, partial, maxillary	$350	not covered		
D6113	Implant/abutment supported removable denture, partial, mandibular	$350	not covered		
D6114	Implant/abutment supported fixed denture, maxillary	$350	not covered		
D6115	Implant/abutment supported fixed denture, mandibular	$350	not covered		
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350	not covered		
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350	not covered		
D6190	Radiographic/surgical implant index, by report	$75	not covered		
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$265	not covered		
D6199	Unspecified implant procedure, by report	$350	not covered		
	Fixed Prosthodontic Services				
***GUIDELINES for Pontics, Onlays, Crowns: Applies to Adult Dental Only** **The total maximum amount chargeable to the member for elective upgraded procedures** (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. **1. Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. **2. Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. **3. Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. **4. Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.					
D6205	Pontic, indirect resin based composite*	not covered	$165		1 of (D2542-D2792, D6205-D6791) per tooth every 5 year period
D6210	Pontic, cast high noble metal*	not covered	$300		
D6211	Pontic, cast predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6212	Pontic, cast noble metal*	not covered	$300		
D6214	Pontic, titanium, and titanium alloys*	not covered	$300		
D6240	Pontic, porcelain fused to high noble metal*	not covered	$300		
D6241	Pontic, porcelain fused to predominantly base metal*	$300	$300		
D6242	Pontic, porcelain fused to noble metal*	not covered	$300		
D6245	Pontic, porcelain/ceramic*	$300	$300		
D6250	Pontic, resin with high noble metal*	not covered	$300		
D6251	Pontic, resin with predominantly base metal*	$300	$300		
D6252	Pontic, resin with noble metal*	not covered	$300		
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	$130		
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis*	not covered	$145		
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered	$130		
D6608	Retainer onlay, porcelain/ceramic, two surfaces*	not covered	$200		
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces*	not covered	$200		
D6610	Retainer onlay, cast high noble metal, two surfaces*	not covered	$200		
D6611	Retainer onlay, cast high noble metal, three or more surfaces*	not covered	$200		
D6612	Retainer onlay, cast base metal, two surfaces	not covered	$200		
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	$200		
D6614	Retainer onlay, cast noble metal, two surfaces*	not covered	$200		
D6615	Retainer onlay, cast noble metal three or more surfaces*	not covered	$200		
D6634	Retainer onlay, titanium*	not covered	$200		
D6710	Retainer crown, indirect resin based composite	not covered	$200		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Fixed Prosthodontic Services (continued)				
D6720	Retainer crown, resin with high noble metal*	not covered	$300		1 of (D2542-D2792, D6205-D6791) per tooth every 5 year period
D6721	Retainer crown, resin with predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6722	Retainer crown, resin with noble metal*	not covered	$300		
D6740	Retainer crown, porcelain/ceramic*	$300	$300		
D6751	Retainer crown, porcelain fused to predominantly base metal*	$300	$300		
D6781	Retainer crown, ¾ cast predominantly base metal	$300	$300		
D6782	Retainer crown, ¾ cast noble metal*	not covered	$300		
D6783	Retainer crown, ¾ porcelain/ceramic*	$300	$300		
D6791	Retainer crown, full cast predominantly base metal	$300	$300		
D6930	Re-cement or re-bond fixed partial denture	$40	$40		
D6980	Fixed partial denture repair, restorative material failure	$95	$95		
D6999	Unspecified fixed prosthodontic procedure, by report	$350	not covered		
	Oral & Maxillofacial Services				
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists					
D7111	Extraction, coronal remnants, primary tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root	$65	$65		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$120	$115		
D7220	Removal of impacted tooth, soft tissue	$95	$85		
D7230	Removal of impacted tooth, partially bony	$145	$145		
D7240	Removal of impacted tooth, completely bony	$160	$160		
D7241	Removal impacted tooth, complete bony, complication	$175	$175		
D7250	Removal of residual tooth roots (cutting procedure)	$80	$75		
D7260	Oroantral fistula closure	$280	$280		
D7261	Primary closure of a sinus perforation	$285	not covered		
D7270	Tooth reimplantation and/or stabilization, accident	$185	not covered	1 (D7270) per arch	
D7280	Exposure of an unerupted tooth	$220	not covered		
D7283	Placement, device to facilitate eruption, impaction	$85	not covered		
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$180	not covered	1 (D7285) per arch per date of service	
D7286	Incisional biopsy of oral tissue, soft	$110	$110	up to 3 (D7286) per date of service	
D7287	Exfoliative cytological sample collection	not covered	$35		
D7288	Brush biopsy, transepithelial sample collection	not covered	$35		
D7290	Surgical repositioning of teeth	$185	not covered	1 (D7290) per arch, for active orthodontic treatment only	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	not covered	1 (D7291) per arch, for active orthodontic treatment only	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$85	$85		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50	$50		
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$120	$120		
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$65	$65		
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$350	not covered	1 (D7340) per arch every 5 year period	
D7350	Vestibuloplasty, ridge extension	$350	not covered	1 (D7350) per arch	
D7410	Excision of benign lesion, up to 1.25 cm	$75	not covered		
D7411	Excision of benign lesion, greater than 1.25 cm	$115	not covered		
D7412	Excision of benign lesion, complicated	$175	not covered		
D7413	Excision of malignant lesion, up to 1.25 cm	$95	not covered		
D7414	Excision of malignant lesion, greater than 1.25 cm	$120	not covered		
D7415	Excision of malignant lesion, complicated	$255	not covered		
D7440	Excision of malignant tumor, up to 1.25 cm	$105	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7441	Excision of malignant tumor, greater than 1.25 cm	$185	not covered		
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$180	not covered		
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$330	not covered		
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$155	not covered		
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$250	not covered		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	not covered		
D7471	Removal of lateral exostosis, maxilla or mandible	$140	$140	1 (D7471) per quadrant	
D7472	Removal of torus palatinus	$145	$140	1 (D7472) per lifetime	
D7473	Removal of torus mandibularis	$140	$140	1 (D7473) per quadrant	
D7485	Reduction of osseous tuberosity	$105	not covered	1 (D7485) per quadrant	
D7490	Radical resection of maxilla or mandible	$350	not covered		
D7510	Incision & drainage of abscess, intraoral soft tissue	$70	$55	1 (D7510) per quadrant, same date of service	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$70	$69	1 (D7511) per quadrant, same date of service	
D7520	Incision & drainage of abscess, extraoral soft tissue	$70	not covered		
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$80	not covered		
D7530	Remove foreign body, mucosa, skin, tissue	$45	not covered	1 (D7530) per date of service	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	not covered	1 (D7540) per date of service	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	$125	1 (D7550) per quadrant per date of service	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	not covered		
D7610	Maxilla, open reduction (teeth immobilized, if present)	$140	not covered		
D7620	Maxilla, closed reduction (teeth immobilized, if present)	$250	not covered		
D7630	Mandible, open reduction (teeth immobilized, if present)	$350	not covered		
D7640	Mandible, closed reduction (teeth immobilized, if present)	$350	not covered		
D7650	Malar and/or zygomatic arch, open reduction	$350	not covered		
D7660	Malar and/or zygomatic arch, closed reduction	$350	not covered		
D7670	Alveolus, closed reduction, may include stabilization of teeth	$170	not covered		
D7671	Alveolus, open reduction, may include stabilization of teeth	$230	not covered		
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	$350	not covered		
D7710	Maxilla, open reduction	$110	not covered		
D7720	Maxilla, closed reduction	$180	not covered		
D7730	Mandible, open reduction	$350	not covered		
D7740	Mandible, closed reduction	$290	not covered		
D7750	Malar and/or zygomatic arch, open reduction	$220	not covered		
D7760	Malar and/or zygomatic arch, closed reduction	$350	not covered		
D7770	Alveolus, open reduction stabilization of teeth	$135	not covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	not covered		
D7780	Facial bones, complicated reduction with fixation and multiple approaches	$350	not covered		
D7810	Open reduction of dislocation	$350	not covered		
D7820	Closed reduction of dislocation	$80	not covered		
D7830	Manipulation under anesthesia	$85	not covered		
D7840	Condylectomy	$350	not covered		
D7850	Surgical discectomy, with/without implant	$350	not covered		
D7852	Disc repair	$350	not covered		
D7854	Synovectomy	$350	not covered		
D7856	Myotomy	$350	not covered		
D7858	Joint reconstruction	$350	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7860	Arthrotomy	$350	not covered		
D7865	Arthroplasty	$350	not covered		
D7870	Arthrocentesis	$90	not covered		
D7871	Non-arthroscopic lysis and lavage	$150	not covered		
D7872	Arthroscopy, diagnosis, with or without biopsy	$350	not covered		
D7873	Arthroscopy: lavage and lysis of adhesions	$350	not covered		
D7874	Arthroscopy: disc repositioning and stabilization	$350	not covered		
D7875	Arthroscopy: synovectomy	$350	not covered		
D7876	Arthroscopy: discectomy	$350	not covered		
D7877	Arthroscopy: debridement	$350	not covered		
D7880	Occlusal orthotic device, by report	$120	not covered		
D7881	Occlusal orthotic device adjustment	$30	not covered		
D7899	Unspecified TMD therapy, by report	$350	not covered		
D7910	Suture of recent small wounds up to 5 cm	$35	not covered		
D7911	Complicated suture, up to 5 cm	$55	not covered		
D7912	Complicated suture, greater than 5 cm	$130	not covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	not covered		
D7940	Osteoplasty, for orthognathic deformities	$160	not covered		
D7941	Osteotomy, mandibular rami	$350	not covered		
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	$350	not covered		
D7944	Osteotomy, segmented or subapical	$275	not covered		
D7945	Osteotomy, body of mandible	$350	not covered		
D7946	LeFort I (maxilla, total)	$350	not covered		
D7947	LeFort I (maxilla, segmented)	$350	not covered		
D7948	LeFort II or LeFort III, without bone graft	$350	not covered		
D7949	LeFort II or LeFort III, with bone graft	$350	not covered		
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	$190	not covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	not covered		
D7952	Sinus augmentation via a vertical approach	$175	not covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	not covered		
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$120	$120	1 (D7960) per arch per date of service	
D7963	Frenuloplasty	$120	$120	1 (D7963) per arch per date of service	
D7970	Excision of hyperplastic tissue, per arch	$175	$176	1 (D7970) per arch per date of service	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of fibrous tuberosity	$100	not covered	1 (D7972) per arch per date of service	
D7979	Non – surgical sialolithotomy	$155	not covered		
D7980	Surgical sialolithotomy	$155	not covered		
D7981	Excision of salivary gland, by report	$120	not covered		
D7982	Sialodochoplasty	$215	not covered		
D7983	Closure of salivary fistula	$140	not covered		
D7990	Emergency tracheotomy	$350	not covered		
D7991	Coronoidectomy	$345	not covered		
D7995	Synthetic graft, mandible or facial bones, by report	$150	not covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	not covered	1 (D7997) per arch per date of service	
D7999	Unspecified oral surgery procedure, by report	$350	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Orthodontic Services				
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350 per course of treatment, regardless of plan year, as long as member remains enrolled in the plan	not covered	age 13 and over	
D8210	Removable appliance therapy		not covered	1 (D8210) per patient, age 6 through 12	
D8220	Fixed appliance therapy		not covered	1 (D8220) per patient, age 6 through 12	
D8660	Pre-orthodontic treatment examination to monitor growth and development		not covered	1 (D8660) every 3 months for a maximum of 6	
D8670	Periodic orthodontic treatment visit		not covered	1 (D8670) per calendar quarter	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		not covered	1 (D8680) per arch for each authorized phase of orthodontic treatment	
D8681	Removable orthodontic retainer adjustment		not covered		
D8691	Repair of orthodontic appliance		not covered	1 (D8691) per appliance	
D8692	Replacement of lost or broken retainer		not covered	1 (D8692) per arch	
D8693	Re-cement or re-bond fixed retainer		not covered	1 (D8693) per provider	
D8694	Repair of fixed retainers, includes reattachment		not covered		
D8696	Repair of orthodontic appliance, maxillary		not covered	1 of (D8696, D8697) per arch	
D8697	Repair of orthodontic appliance, mandibular		not covered		
D8698	Re-cement or re-bond fixed retainer, maxillary		not covered	1 of (D8698, D8699) per arch per provider	
D8699	Re-cement or re-bond fixed retainer, mandibular		not covered		
D8701	Repair of fixed retainer, includes reattachment, maxillary		not covered		
D8702	Repair of fixed retainer, includes reattachment, mandibular		not covered		
D8703	Replacement of lost or broken retainer, maxillary		not covered	1 of (D8703, D8704) per arch	
D8704	Replacement of lost or broken retainer, mandibular		not covered		
D8999	Unspecified orthodontic procedure, by report		not covered		
	Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure	$30	$28	1 (D9110) per date of service	
D9120	Fixed partial denture sectioning	$95	$95		
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$10	$10	1 (D9210) per date of service	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15		
PEDIATRIC GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification. **ADULT GUIDELINE:** Deep Sedation and IV Conscious Sedation are covered benefits only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.					
D9222	Deep sedation/general anesthesia, first 15 minutes	$45	$45		
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$45	$45		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	not covered		
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minutes	$60	$45		
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$60	$45		
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$65	not covered		
D9310	Consultation, other than requesting dentist	$50	$45		
D9311	Consultation with a medical health care professional	no charge	not covered		
D9410	House/extended care facility call	$50	not covered		
D9420	Hospital or ambulatory surgical center call	$135	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Adjunctive General Services (continued)				
D9430	Office visit, observation, regular hours, no other services	$20	$12	1 (D9430) per date of service per provider	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	$45	$40	1 (D9440) per date of service per provider	1 (D9440) per date of service per provider
D9450	Case presentation, detailed & extensive treatment	not covered	no charge		
D9610	Therapeutic parenteral drug, single administration	$30	not covered	4 (D9610) per date of service	
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$40	not covered	4 (D9612) per date of service	
D9910	Application of desensitizing medicament	$20	$22	1 (D9910) per tooth every 12 months, for permanent teeth only	
D9930	Treatment of complications, post surgical, unusual, by report	$35	not covered	1 (D9930) per date of service per provider	
D9942	Repair and/or reline of occlusal guard	not covered	$35		
D9944	Occlusal guard, hard appliance, full arch	not covered	$115		1 of (D9944-D9946) every 5 year period
D9945	Occlusal guard, soft appliance, full arch	not covered	$115		
D9946	Occlusal guard, hard appliance, partial arch	not covered	$115		
D9950	Occlusion analysis, mounted case	$120	not covered	1 (D9950) every 12 months, age 13 and over	
D9951	Occlusal adjustment, limited	$45	$45	1 (D9951) per quad every 12 months per provider, age 13 and over	1 (D9951) per quad every 12 months per provider
D9952	Occlusal adjustment, complete	$210	$210	1 (D9952) every 12 months, age 13 and over	
D9999	Unspecified adjunctive procedure, by report	no charge	not covered		

Pediatric Benefits – Children to the age of 19[1]

Adult Benefits – Benefits for eligible members age 19 and over[2]

The Out-of-Pocket Maximum is the maximum amount of money that a covered Pediatric Enrollee can pay in copays for all allowable expenses, including orthodontic copayments, in any Plan Year. A single Pediatric Enrollee will have an out-of-pocket maximum of $350. A family with two (2) or more Pediatric Enrollees will have a combined Out-of-Pocket Maximum of $700.

Once the amount paid by all Pediatric Enrollee(s) equals the Out-of-Pocket Maximum shown above, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Plan Year for covered services. Adult benefits are not subject to Out-of-Pocket Maximums.

Copayments made by each individual child for in-network services contribute to the Out-of-Pocket Maximum. Out-of-network services are not covered and do not accumulate to the Out-of-Pocket Maximum.

Only copayments for services provided by a contracted provider will count toward the Out-of-Pocket Maximum. Payment for services that are Optional, performed by a non-contracted provider, or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual 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 Customer Service department at 888-844-3344 for instruction on how to submit. Proof that the Out-of-Pocket Maximum has been reached must be submitted to the Plan.

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General Exclusions:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
5. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind are not covered by the Dental Plan. Refer to your Health Plan's Evidence of Coverage for benefit information.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
10. Any service that is not specifically listed as a covered benefit, including adult services noted as not covered on the copayment schedule.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
14. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
15. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.
16. Tooth whitening, adult orthodontia, implants, veneers, and adult services noted as "Not Covered" on the Copayment Schedule are not covered services.

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") follows State and Federal civil rights laws. LIBERTY does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, please contact us between 8 a.m. to 5 p.m (PST) by calling (888) 844-3344. Or, if you cannot hear or speak well, please call (800) 735-2929

HOW TO FILE A GRIEVANCE

If you believe that LIBERTY has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with LIBERTY's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m to 5 p.m (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:
  P.O. Box 26110
  Santa Ana, CA 92799
- In person: Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Michele Villados
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your health plan's phone number at 1-888-844-3344. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o pedir información escrita (en su idioma o en algún formato diferente, como Braille o tipo de letra más grande), primero llame al número de teléfono de su plan de salud al 1-888-844-3344. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示： 您與您的醫生或保健計劃工作人員交談時，可獲得免費口譯服務。如需口譯員服務或索取（用給您的語言或布萊葉盲文或大字體等不同格式提供的）書面資料，請先打電話給您的保健計劃，電話號碼 1-888-844-3344。會講（您的語言）的人士將為您提供協助。 如需更多協助，請打電話給 HMO 協助中心，電話號碼 1-888-466-2219。 (Cantonese or Mandarin)

هام: يمكنك الحصول على خدمات مترجم فوري مجاناً للتحدث مع طبيبك أو خطتك الصحية. للحصول على مترجم فوري أو لطلب معلومات مكتوبة (بلغتك أو بصيغة أخرى، مثل طريقة برايل أو بخط كبير)، اتصل أولاً برقم هاتف الخطة الصحية على 1-888-844-3344. سيساعدك شخص ما يتحدث (نفس لغتك). إذا كنت تريد المزيد من المساعدة، اتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել Ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանչի ծառայություններից առանց որևէ վճարի: Թարգմանիչ ունենալու կամ գրավոր տեղեկություն խնդրելու համար (հայերենով կամ մեկ այլ ձևաչափով, օրինակ՝ Բրայլը կամ մեծ տառաչափը), նախ զանգահարեք առողջապահական ծրագրի հեռախոսահամարով՝ 1-888-844-3344: Ցանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարեք Առողջապահական օժանդակության կազմակերպության (HMO) Օգնության կենտրոն՝ 1-888-466-2219 հեռախոսահամարով: (Armenian)

សារៈសំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគំរោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ែល ឬអក្សរពុម្ពធំៗ) សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-888-844-3344 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការថែរក្សាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

مهم: برای گفتگو با پزشک معالج یا طرح بیمه می توانید بطور رایگان مترجم حضوری داشته باشید. برای درخواست مترجم حضوری یا برای دریافت اطلاعات بصورت کتبی (به زبان خود، یا با فرمت های دیگر مانند بریل یا چاپ درشت) ابتدا با شماره تلفن طرح خود یعنی 1-888-844-3344 تماس حاصل نمایید. فردی که (زبان شما را) صحبت می کند، می تواند شما را یاری دهد. اگر به کمک بیشتر نیاز دارید با مرکز کمک رسانی اچ ام او (HMO) به شماره 1-888-466-2219 تماس حاصل نمایید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav tau cov ntaub ntawv (sau ua koj yam lus los sis ua lwm yam ntawv, zoo li ua lus Braille los sis ua ntawv loj loj), xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-888-844-3344. Yuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜과 대화하실 때 무료 통역 서비스를 받으실 수 있습니다. 통역을 구하시거나 문자 정보(한국어 번역본 또는 점자나 큰 글자 같이 다른 형식으로 된 정보)를 요청하시려면, 가입하신 건강 플랜에 1-888-844-3344 로 먼저 전화하십시오. 한국어를 하는 사람이 도와드릴 수 있습니다. 도움이 더 필요하시면 HMO 도움 센터에 1-888-466-2219 로 연락하십시오. (Korean)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить услуги переводчика или письменную информацию (на русском языке или в другом формате, например, шрифтом Брайля или крупным шрифтом), позвоните в свой страховой план по телефону 1-888-844-3344. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o planong pangkalusugan. Upang makakuha ng isang tagasalin o upang humiling ng nakasulat na impormasyon (sa iyong wika o sa ibang anyo, tulad ng Braille o malalaking letra), tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-888-844-3344. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng karagdagang tulong, tawagan ang Sentro ng Pagtulong ng HMO sa 1-888-466-2219. (Tagalog)

LIBERTY DENTAL PLAN

LƯU Ý QUAN TRỌNG: Quý vị có thể được cấp dịch vụ thông dịch miễn phí khi đi khám tại văn phòng bác sĩ hoặc khi cần liên lạc với chương trình bảo hiểm sức khỏe của quý vị. Để được cấp dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt hoặc bằng một hình thức khác như chữ nổi hoặc bản in bằng chữ khổ lớn, trước tiên hãy gọi số điện thoại của chương trình bảo hiểm sức khỏe của quý vị tại 1-888-844-3344. Sẽ có người nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, vui lòng gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)

ENPÒTAN: Ou kapab jwenn yon moun pou entèprete pou ou gratis pou w ka pale avèk doktè ou oswa plan sante ou. Pou jwenn yon entèprèt oswa mande enfòmasyon ekri (nan lang kreyòl ayisyen oswa yon diferan fòma tankou ekriti Bray oswa pi gwo lèt), rele nimewo telefòn plan sante ou a ki se 1-888-844-3344. Yon moun ki pale kreyòl ayisyen kapab ede ou. Si ou bezwen plis asistans, rele HMO Help Center nan nimewo 1-888-466-2219. (Haitian Creole)

IMPORTANTE: Você pode usar um intérprete gratuitamente para falar com seu médico ou comunicar-se com seu plano de saúde. Para pedir um intérprete ou solicitar informações por escrito (no seu idioma ou em outro formato, como em Braille ou em letras grandes), primeiramente, ligue para o telefone de seu plano de saúde no número 1-888-844-3344. Uma pessoa que fala português irá atendê-lo. Se precisar de mais ajuda, ligue para o HMO Help Center no telefone 1-888-466-2219. (Portuguese)

ਮਹੱਤਵਪੂਰਨ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਯੋਜਨਾ ਲਈ ਗੱਲ ਕਰਨ ਵਾਸਤੇ ਮੁਫਤ ਅਨੁਵਾਦਕ ਪਾ ਸਕਦੇ ਹੋ| ਅਨੁਵਾਦਕ ਪਾਉਣ ਲਈ ਜਾਂ ਲਿਖਤੀ ਜਾਣਕਾਰੀ (ਆਪਣੀ ਭਾਸ਼ਾ ਜਾਂ ਵੱਖਰੇ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਅੱਖਰ) ਦੀ ਬੇਨਤੀ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ 1-888-844-3344 'ਤੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਦੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ| ਜੋ ਵੀ (ਤੁਹਾਡੀ ਭਾਸ਼ਾ) ਬੋਲੇਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ| ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-888-466-2219 'ਤੇ HMO Help Center (ਐਚ.ਐਮ.ਓ. ਸਹਾਇਤਾ ਸੈਂਟਰ) ਨੂੰ ਕਾਲ ਕਰੋ| (Punjabi)

重要 通訳を通して医師や医療保険会社とお話しいただけます。料金はかかりません。日本語でサポートを受けたり、日本語で書かれた情報を入手するには、あなたの医療保険会社（1-888-844-3344）までお電話ください。日本語が話せるスタッフがお手伝いします。さらなるサポートが必要な場合は、HMO Help Center（1-888-466-2219）までお電話ください。(Japanese)