MO Family Value Dental Plan

Individual Out-of-Pocket Maximum: $375 Calendar Year (applies to Pediatric only)
Family Out-of-Pocket Maximum: $750 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 see a specialist if the services are dentally necessary and outside the scope of general dentistry. Members may directly refer to a specialist.

ADA Code	Description	Pediatric Copay[1]	Adult Copay[2]	Limitations
	Diagnostic Services			
D0120	Periodic oral evaluation	$0	$15	1 of (D0120, D0140, D0150, D0180) every 6 months
D0140	Limited oral evaluation	$0	$15	
D0150	Comprehensive oral evaluation	$0	$15	
D0180	Comprehensive periodontal evaluation	$0	$15	
D0160	Oral evaluation, problem focused	$0	$15	
D0210	Intraoral, complete series of radiographic images	$0	$50	1 of (D0210, D0330) every 60 months
D0330	Panoramic radiographic image	$0	$50	
D0220	Intraoral, periapical, first radiographic image	$0	$14	
D0230	Intraoral, periapical, each add 'l radiographic image	$0	$10	
D0240	Intraoral, occlusal radiographic image	$0	$15	
D0270	Bitewing, single radiographic image	$0	$10	1 of (D0270-D0277) every 6 months
D0272	Bitewings, two radiographic images	$0	$28	
D0274	Bitewings, four radiographic images	$0	$35	
D0277	Vertical bitewings, 7 to 8 radiographic images	$0	NPB	
D0340	2D cephalometric radiographic image, measurement and analysis	$94	NPB	In conjunction with orthodontic coverage
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$40	NPB	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	$61	NPB	
D0470	Diagnostic casts	$0	$49	
	Preventive Services			
D1110	Prophylaxis, adult	$0	$30	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	$0	NPB	
D1206	Topical application of fluoride varnish	$0	NPB	2 of (D1206, D1208) every 12 months
D1208	Topical application of fluoride, excluding varnish	$0	$25	
D1351	Sealant, per tooth	$0	NPB	1 of (D1351, D1352) per tooth every 36 months, 1st and 2nd permanent molars
D1352	Preventive resin restoration, permanent tooth	$0	NPB	
D1353	Sealant repair, per tooth	$0	NPB	1 per tooth every 36 months, 1st and 2nd permanent molars
D1510	Space maintainer, fixed, unilateral, per quadrant	$0	$150	
D1516	Space maintainer, fixed, bilateral, maxillary	$0	$175	
D1517	Space maintainer, fixed, bilateral, mandibular	$0	$175	
D1520	Space maintainer, removable, unilateral, per quadrant	$0	$200	
D1526	Space maintainer, removable, bilateral, maxillary	$0	$225	
D1527	Space maintainer, removable, bilateral, mandibular	$0	$225	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$0	$25	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$0	$25	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0	$25	
D1575	Distal shoe space maintainer, fixed, per quadrant	$0	$150	
	Restorative Services			
D2140	Amalgam, one surface, primary or permanent	$40	$65	
D2150	Amalgam, two surfaces, primary or permanent	$45	$75	
D2160	Amalgam, three surfaces, primary or permanent	$50	$90	
D2161	Amalgam, four or more surfaces, primary or permanent	$60	$125	
D2330	Resin-based composite, one surface, anterior	$50	$80	
D2331	Resin-based composite, two surfaces, anterior	$60	$90	
D2332	Resin-based composite, three surfaces, anterior	$70	$105	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$80	$130	
***GUIDELINES for Inlays, Onlays, and Single Crowns:** **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. The Contracted Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment.				
D2510	Inlay, metallic, one surface	$225	$370	1 of (D2510-D2794, D6058-D6077, D6210-D6794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	$365	$395	
D2530	Inlay, metallic, three or more surfaces	$325	$450	
D2542	Onlay, metallic, two surfaces	$345	$500	
D2543	Onlay, metallic, three surfaces	$350	$530	
D2544	Onlay, metallic, four or more surfaces	$350	$615	
D2740	Crown, porcelain/ceramic*	$350	$640	
D2750	Crown, porcelain fused to high noble metal*	$350	$675	
D2751	Crown, porcelain fused to predominantly base metal	$350	$585	
D2752	Crown, porcelain fused to noble metal*	$350	$630	
D2780	Crown, ¾ cast high noble metal*	$350	$630	
D2781	Crown, ¾ cast predominantly base metal	$350	$575	

LIBERTY Dental Plan | Missouri Individual Exchange

ADA Code	Description	Pediatric Copay[1]	Adult Copay[2]	Limitations
	Restorative Services (continued)			
D2783	Crown, ¾ porcelain/ceramic*	$350	$595	1 of (D2510-D2794, D6058-D6077, D6210-D6794) per tooth every 60 months
D2790	Crown, full cast high noble metal*	$350	$620	
D2791	Crown, full cast predominantly base metal	$350	$580	
D2792	Crown, full cast noble metal*	$350	$595	
D2794	Crown, titanium and titanium alloys*	$350	$650	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$45	$47	
D2920	Re-cement or re-bond crown	$50	$51	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$100	NPB	1 of (D2929-D2931) per tooth every 60 months
D2930	Prefabricated stainless steel crown, primary tooth	$75	NPB	
D2931	Prefabricated stainless steel crown, permanent tooth	$100	NPB	
D2940	Protective restoration	$60	NPB	
D2950	Core buildup, including any pins when required	$95	$145	1 (D2950) per tooth every 60 months
D2951	Pin retention, per tooth, in addition to restoration	$30	$34	
D2954	Prefabricated post and core in addition to crown	$115	$160	1 (D2954) per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure	$105	$125	
D2981	Inlay repair necessitated by restorative material failure	$65	$65	
D2982	Onlay repair necessitated by restorative material failure	$80	$80	
D2983	Veneer repair necessitated by restorative material failure	$65	$65	
D2990	Resin infiltration of incipient smooth surface lesions	$15	$15	1 (D2990) every 36 months
	Endodontic Services			
D3220	Therapeutic pulpotomy (excluding final restoration)	$75	$95	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$70	$75	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$80	$94	1 of (D3230, D3240) per tooth per lifetime
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$80	$105	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$270	$405	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$320	$490	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$350	$610	
D3346	Retreatment of previous root canal therapy, anterior	$350	$405	
D3347	Retreatment of previous root canal therapy, premolar	$350	$490	
D3348	Retreatment of previous root canal therapy, molar	$350	$590	
D3351	Apexification/recalcification, initial visit	$105	NPB	
D3352	Apexification/recalcification, interim medication replacement	$110	NPB	
D3353	Apexification/recalcification, final visit	$230	NPB	
D3410	Apicoectomy, anterior	$275	$225	
D3421	Apicoectomy, premolar (first root)	$285	$275	
D3425	Apicoectomy, molar (first root)	$305	$295	
D3426	Apicoectomy, (each additional root)	$115	$175	
D3450	Root amputation, per root	$145	$160	
D3920	Hemisection, not including root canal therapy	$105	$215	
	Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$205	$250	1 of (D4210-D4264) per site/quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$125	$120	
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$125	$74	
D4240	Gingival flap procedure, four or more teeth per quadrant	$225	$425	
D4241	Gingival flap procedure, one to three teeth per quadrant	$225	$225	
D4260	Osseous surgery, four or more teeth per quadrant	$350	$450	
D4261	Osseous surgery, one to three teeth per quadrant	$200	$375	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$245	$450	
D4264	Bone replacement graft, retained natural tooth, each additional site	$245	$450	
D4270	Pedicle soft tissue graft procedure	$245	$450	
D4273	Autogenous connective tissue graft procedure, first tooth	$265	$380	
D4275	Non-autogenous connective tissue graft, first tooth	$245	$300	1 of (D4275, D4285) per tooth every 36 months
D4277	Free soft tissue graft, first tooth	$200	$275	
D4278	Free soft tissue graft, each additional tooth	$200	$135	
D4249	Clinical crown lengthening, hard tissue	$175	$375	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$265	$380	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$245	$300	1 of (D4275, D4285) per tooth every 36 months
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	$145	1 of (D4341, D4342) per site/quad every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$90	$130	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0	$30	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	$60	$105	1 (D4355) per lifetime
D4910	Periodontal maintenance	$80	$85	4 (D4910) every 12 months
	Removable Prosthodontic Services			
D5110	Complete denture, maxillary	$350	$755	1 of (D5110-D5224, D5282, D5283) per arch every 60 months
D5120	Complete denture, mandibular	$350	$755	
D5130	Immediate denture, maxillary	$350	$825	
D5140	Immediate denture, mandibular	$350	$825	
D5211	Maxillary partial denture, resin base	$350	$505	
D5212	Mandibular partial denture, resin base	$350	$505	
D5213	Maxillary partial denture, cast metal, resin base	$350	$715	
D5214	Mandibular partial denture, cast metal, resin base	$350	$715	
D5221	Immediate maxillary partial denture, resin base	$350	$505	

ADA Code	Description	Pediatric Copay[1]	Adult Copay[2]	Limitations
	Removable Prosthodontic Services (continued)			
D5222	Immediate mandibular partial denture, resin base	$350	$505	1 of (D5110-D5224, D5282, D5283) per arch every 60 months
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$350	$715	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$350	$715	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$305	NPB	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$305	NPB	
D5410	Adjust complete denture, maxillary	$40	$38	1 of (D5410-D5422) per arch every 12 months
D5411	Adjust complete denture, mandibular	$40	$38	
D5421	Adjust partial denture, maxillary	$40	$38	
D5422	Adjust partial denture, mandibular	$40	$38	
D5511	Repair broken complete denture base, mandibular	$80	$96	
D5512	Repair broken complete denture base, maxillary	$80	$96	
D5520	Replace missing or broken teeth, complete denture	$70	$88	
D5611	Repair resin partial denture base, mandibular	$75	$95	
D5612	Repair resin partial denture base, maxillary	$75	$95	
D5621	Repair cast partial framework, mandibular	$105	$135	
D5622	Repair cast partial framework, maxillary	$105	$135	
D5630	Repair or replace broken retentive clasping materials, per tooth	$85	$135	
D5640	Replace broken teeth, per tooth	$95	$85	
D5650	Add tooth to existing partial denture	$80	$115	
D5660	Add clasp to existing partial denture, per tooth	$100	$125	
D5710	Rebase complete maxillary denture	$205	$307	1 of (D5710-D5761) per arch every 36 months
D5711	Rebase complete mandibular denture	$205	$307	
D5720	Rebase maxillary partial denture	$205	$290	
D5721	Rebase mandibular partial denture	$215	$290	
D5730	Reline complete maxillary denture, direct	$125	$180	
D5731	Reline complete mandibular denture, direct	$125	$180	
D5740	Reline maxillary partial denture, direct	$125	$175	
D5741	Reline mandibular partial denture, direct	$115	$175	
D5750	Reline complete maxillary denture, indirect	$180	$235	
D5751	Reline complete mandibular denture, indirect	$180	$235	
D5760	Reline maxillary partial denture, indirect	$180	$220	
D5761	Reline mandibular partial denture, indirect	$170	$220	
D5850	Tissue conditioning, maxillary	$70	$105	
D5851	Tissue conditioning, mandibular	$80	$105	
	Implant Services			
	***GUIDELINES for Implant Abutments:** **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. The Contracted Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment.			
D6010	Surgical placement of implant body, endosteal	$350	NPB	1 of (D6010, D6040, D6050) per tooth every 60 months
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	$350	NPB	1 (D6012) per tooth every 60 months
D6040	Surgical placement: eposteal implant	$350	NPB	1 of (D6010, D6040, D6050) per tooth every 60 months
D6050	Surgical placement: transosteal implant	$350	NPB	
D6055	Connecting bar, implant supported or abutment supported	$350	NPB	1 (D6055) per tooth every 60 months
D6056	Prefabricated abutment, includes modification and placement	$350	NPB	1 of (D6056, D6057) per tooth every 60 months
D6057	Custom fabricated abutment, includes placement	$350	NPB	
D6058	Abutment supported porcelain/ceramic crown*	$350	NPB	1 of (D2510-D2794, D6058-D6077, D6210-D6794) per tooth every 60 months
D6059	Abutment supported porcelain fused to high noble crown*	$350	NPB	
D6060	Abutment supported porcelain fused to base metal crown	$350	NPB	
D6061	Abutment supported porcelain fused to noble metal crown*	$350	NPB	
D6062	Abutment supported cast metal crown, high noble*	$350	NPB	
D6063	Abutment supported cast metal crown, base metal	$350	NPB	
D6064	Abutment supported cast metal crown, noble metal*	$350	NPB	
D6065	Implant supported porcelain/ceramic crown*	$350	NPB	
D6066	Implant supported crown, porcelain fused to high noble alloys*	$350	NPB	
D6067	Implant supported crown, high noble alloys*	$350	NPB	
D6068	Abutment supported retainer, porcelain/ceramic FPD*	$350	NPB	
D6069	Abutment supported retainer, metal FPD, high noble*	$350	NPB	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$350	NPB	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble*	$350	NPB	
D6072	Abutment supported retainer, cast metal FPD, high noble*	$350	NPB	
D6073	Abutment supported retainer, cast metal FPD, base metal	$350	NPB	
D6074	Abutment supported retainer, cast metal FPD, noble*	$350	NPB	
D6075	Implant supported retainer for ceramic FPD*	$350	NPB	
D6076	Implant supported retainer for porcelain fused metal FPD	$350	NPB	
D6077	Implant supported retainer for cast metal FPD	$350	NPB	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$50	NPB	1 (D6080) per tooth every 60 months
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$0	NPB	1 (D6081) every 12 months, not on same day or within 60 days of D1110, D1120, D4341, D4342, D4355, D4910
D6090	Repair implant supported prosthesis, by report	$80	NPB	1 (D6090) per tooth every 60 months

ADA Code	Description	Pediatric Copay[1]	Adult Copay[2]	Limitations
	Implant Services (continued)			
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$20	NPB	1 (D6091) per tooth every 60 months
D6095	Repair implant abutment, by report	$230	NPB	1 (D6095) per tooth every 60 months
D6100	Surgical removal of implant body	$180	NPB	1 (D6100) per tooth every 60 months
D6101	Debridement of a peri-implant defect(s), surrounding single implant, including flap entry/closure	$165	NPB	1 of (D6101, D6102) per site every 60 months
D6102	Debridement and osseous contouring of a peri-implant defect(s) surrounding single implant, including flap entry/closure	$350	NPB	
D6103	Bone graft for repair of peri-implant defect, does not include flap entry and closure	$175	NPB	
D6104	Bone graft at time of implant placement	$165	NPB	
D6110	Implant/abutment supported removable denture, maxillary	$350	NPB	
D6111	Implant/abutment supported removable denture, mandibular	$350	NPB	
D6112	Implant/abutment supported removable denture, partial, maxillary	$350	NPB	
D6113	Implant/abutment supported removable denture, partial, mandibular	$350	NPB	
D6114	Implant/abutment supported fixed denture, maxillary	$350	NPB	1 of (D6114-D6117) per arch every 60 months
D6115	Implant/abutment supported fixed denture, mandibular	$350	NPB	
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350	NPB	
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350	NPB	
D6190	Radiographic/surgical implant index, by report	$130	NPB	1 (D6190) every 60 months
	Fixed Prosthodontic Services			
***GUIDELINES for Bridges:** **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. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment.			
D6210	Pontic, cast high noble metal*	$350	$575	1 of (D2510-D2794, D6058-D6077, D6210-D6794) per tooth every 60 months
D6211	Pontic, cast predominantly base metal	$350	$540	
D6212	Pontic, cast noble metal*	$350	$560	
D6214	Pontic, titanium, and titanium alloys*	$350	NPB	
D6240	Pontic, porcelain fused to high noble metal*	$350	$600	
D6241	Pontic, porcelain fused to predominantly base metal	$380	$560	
D6242	Pontic, porcelain fused to noble metal*	$400	$575	
D6245	Pontic, porcelain/ceramic*	$350	$525	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$210	NPB	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis*	$210	NPB	
D6549	Resin retainer, for resin bonded fixed prosthesis	$210	NPB	
D6740	Retainer crown, porcelain/ceramic*	$350	$640	
D6750	Retainer crown, porcelain fused to high noble metal*	$350	$675	
D6751	Retainer crown, porcelain fused to predominantly base metal	$350	$585	
D6752	Retainer crown, porcelain fused to noble metal*	$350	$630	
D6780	Retainer crown, ¾ cast high noble metal*	$350	$600	
D6781	Retainer crown, ¾ cast predominantly base metal	$350	$575	
D6782	Retainer crown, ¾ cast noble metal*	$350	$545	
D6783	Retainer crown, ¾ porcelain/ceramic*	$350	$590	
D6790	Retainer crown, full cast high noble metal*	$350	$620	
D6791	Retainer crown, full cast predominantly base metal	$350	$580	
D6792	Retainer crown, full cast noble metal*	$350	$597	
D6794	Retainer crown, titanium and titanium alloys*	$350	NPB	
D6930	Re-cement or re-bond fixed partial denture	$60	$60	
D6980	Fixed partial denture repair, restorative material failure	$140	$175	
	Oral & Maxillofacial Services			
D7140	Extraction, erupted tooth or exposed root	$130	$78	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$160	$150	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	$172	
D7230	Removal of impacted tooth, partially bony	$200	$220	
D7240	Removal of impacted tooth, completely bony	$250	$240	
D7241	Removal impacted tooth, complete bony, complication	$250	$278	
D7250	Removal of residual tooth roots (cutting procedure)	$200	$147	
D7251	Coronectomy, intentional partial tooth removal	$35	$230	
D7270	Tooth reimplantation and/or stabilization, accident	$135	NPB	
D7280	Exposure of an unerupted tooth	$105	NPB	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$75	$162	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$95	$130	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$95	$210	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$145	$190	
D7471	Removal of lateral exostosis, maxilla or mandible	$295	$360	
D7510	Incision & drainage of abscess, intraoral soft tissue	$95	$85	
D7910	Suture of recent small wounds up to 5 cm	$75	NPB	
D7921	Collection and application of autologous blood concentrate product	$230	NPB	1 (D7921) every 36 months
D7953	Bone replacement graft for ridge preservation, per site	$250	$265	
D7971	Excision of pericoronal gingiva	$55	NPB	

LIBERTY Dental Plan | Missouri Individual Exchange

ADA Code	Description	Pediatric Copay[1]	Adult Copay[2]	Limitations
	Orthodontic Services			
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. All copayments paid by the enrollee, including orthodontic copayments, apply towards the annual Out of Pocket Maximum.				
D8010	Limited orthodontic treatment of the primary dentition	$350	NPB	
D8020	Limited orthodontic treatment of the transitional dentition	$350	NPB	
D8030	Limited orthodontic treatment of the adolescent dentition	$350	NPB	
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	NPB	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	NPB	
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	NPB	
D8210	Removable appliance therapy	$88	NPB	
D8220	Fixed appliance therapy	$127	NPB	
D8660	Pre-orthodontic treatment examination to monitor growth and development	$50	NPB	
D8670	Periodic orthodontic treatment visit	$30	NPB	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$100	NPB	
	Adjunctive General Services			
D9110	Palliative (emergency) treatment, minor procedure	$0	$55	
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 moderate sedation, deep sedation or general anesthesia	$0	$0	
D9222	Deep sedation/general anesthesia, first 15 minute increment	$60	$82	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$60	$82	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$70	$67	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$70	$67	
D9310	Consultation, other than requesting dentist	$0	$55	
D9610	Therapeutic parenteral drug, single administration	$30	$31	
D9930	Treatment of complications, post surgical, unusual, by report	$30	$42	
D9944	Occlusal guard, hard appliance, full arch	$310	NPB	1 of (D9944-D9946) every 12 months, age 13 and over
D9945	Occlusal guard, soft appliance, full arch	$310	NPB	
D9946	Occlusal guard, hard appliance, partial arch	$310	NPB	
D9991	Dental case management, addressing appointment compliance barriers	$0	$0	
D9992	Dental case management, care coordination	$0	$0	
D9993	Dental case management, motivational interviewing	$0	$0	
D9994	Dental case management, patient education to improve oral health literacy	$0	$0	

NPB Not Plan Benefit

[1] Pediatric Benefits – Apply to dependents to the age of 19

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

Out-of-Pocket Maximum means the maximum amount of money 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 multiple child annual Out of-Pocket maximum. Once the amount paid by all Pediatric Enrollee(s) equals the annual Out-of-Pocket Maximum shown above, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services.

Payment for services that are Optional, that are upgraded treatment (such as precious or semi-precious metals and material upgrades) or that are not covered under the Contract 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 877-877-1893 for instruction on how to submit. Proof that the Out-of-Pocket Maximum has been reached must be submitted to LIBERTY Dental Plan.

Exclusions:

Except as specifically provided, the following services, supplies, or charges are not covered:

1 Services and treatment 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, we 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.
2 Services and treatment which are experimental or investigational.
3 Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
4 Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
5 Services and treatment performed prior to your effective date of coverage.
6 Services and treatment incurred after the termination date of your coverage unless otherwise indicated.
7 Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
8 Services and treatment resulting from your failure to comply with professionally prescribed treatment.
9 Telephone consultations.
10 Any charges for failure to keep a scheduled appointment.
11 Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
12 Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD).
13 Services or treatment provided as a result of intentionally self-inflicted injury or illness.
14 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.
15 Office infection control charges.
16 Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays.
17 State or territorial taxes on dental services performed.
18 Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.
19 Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
20 Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
21 Those which are for specialized procedures and techniques.
22 Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
23 Duplicate, provisional and temporary devices, appliances, and services.
24 Plaque control programs, oral hygiene instruction, and dietary instructions.
25 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.
26 Gold foil restorations.
27 Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
28 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.
29 Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
30 Charges by the provider for completing dental forms.
31 Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it.
32 Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners.
33 Cone Beam Imaging and Cone Beam MRI procedures.
34 Sealants for teeth other than permanent molars.
35 Replacement of dentures that have been lost, stolen or misplaced.
36 Orthodontic care for dependent children age 19 and over.
37 Repair of damaged orthodontic appliances.

Exclusions Continued:

38 Replacement of lost or missing appliances.

39 Fabrication of athletic mouth guard.

40 Internal and external bleaching.

41 Nitrous oxide.

42 Oral sedation.

43 Topical medicament center.

44 Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.

45 When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by the dental plan.

46 When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by the dental plan.