



NV Family Plus Dental Plan

Individual Out of Pocket Maximum: \$350 (applies to Pediatric only)

Family Out of Pocket Maximum: \$700 (applies to Pediatric only)

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

ADA Code	Description	Pediatric Copay	Adult Copay	Pediatric Limitations	Adult Limitation
Diagnostic Services					
D0120	Periodic oral evaluation	\$5	\$0	2 of (D0120, D0150) per plan year	2 of (D0120, D0150, D0180) per plan year
D0140	Limited oral evaluation	\$5	\$0		
D0145	Oral evaluation under age 3	\$5	NPB		
D0150	Comprehensive oral evaluation	\$5	\$0	2 of (D0120, D0150) per plan year	2 of (D0120, D0150, D0180) per plan year
D0160	Oral evaluation, problem focused	\$5	\$0		
D0170	Re-evaluation, limited, problem focused	\$5	\$0		
D0171	Re-evaluation, post operative office visit	\$10	\$0		
D0180	Comprehensive periodontal evaluation	NPB	\$0		2 of (D0120, D0150, D0180) per plan year
D0210	Intraoral, complete series of radiographic images	\$25	\$0	1 (D0210) every 11 months	1 (D0210) every 11 months
D0220	Intraoral, periapical, first radiographic image	\$5	\$0		
D0230	Intraoral, periapical, each add'l radiographic image	\$5	\$0		
D0240	Intraoral, occlusal radiographic image	\$5	\$0	2 (D0240) every 12 months	2 (D0240) every 12 months
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	NPB	\$0		
D0251	Extra-oral posterior dental radiographic image	NPB	\$0		
D0270	Bitewing, single radiographic image	\$5	\$0	1 of (D0270, D0272, D0274) every 6 months	1 of (D0270-D0277) every 6 months
D0272	Bitewings, two radiographic images	\$5	\$0		
D0273	Bitewings, three radiographic images	\$5	\$0		
D0274	Bitewings, four radiographic images	\$5	\$0	1 of (D0270, D0272, D0274) every 6 months	
D0277	Vertical bitewings, 7 to 8 radiographic images	\$5	\$0		
D0322	Tomographic survey	\$100	NPB		
D0330	Panoramic radiographic image	\$35	\$0	1 (D0330) every three plan years	1 (D0330) every three plan years
D0340	2D cephalometric radiographic image, measurement and analysis	\$35	NPB		
D0350	2D oral/facial photographic image, intra-orally/extra-orally	\$25	NPB		
D0351	3D photographic image	\$25	NPB		
D0415	Collection of microorganisms for culture	\$25	\$0		
D0416	Viral culture	\$25	NPB		
D0425	Caries susceptibility tests	NPB	\$0		
D0460	Pulp vitality tests	\$10	\$0		
D0470	Diagnostic casts	\$26	NPB		
D0472	Accession of tissue, gross exam, prep & report	NPB	\$0		
D0473	Accession of tissue, gross/micro. exam, prep, report	NPB	\$0		
D0474	Accession of tissue, gross/micro. exam, report	NPB	\$0		
D0486	Accession of transepithelial cytologic sample, prep, written report	\$35	NPB		
D0502	Other oral pathology procedures, by report	\$40	NPB		
D0601	Caries risk assessment and documentation, low risk	\$0	NPB		
D0602	Caries risk assessment and documentation, moderate risk	\$0	NPB		
D0603	Caries risk assessment and documentation, high risk	\$0	NPB		
Preventive Services					
D1110	Prophylaxis, adult	\$10	\$0	2 of (D1110, D1120, D4346, D4910) per plan year	2 of (D1110, D4346, D4910) per plan year
D1120	Prophylaxis, child	\$10	NPB		
D1206	Topical application of fluoride varnish	\$0	\$0	2 of (D1206, D1208) per plan year	2 of (D1206, D1208) per plan year
D1208	Topical application of fluoride, excluding varnish	\$0	\$0		
D1310	Nutritional counseling for control of dental disease	\$0	\$0		
D1320	Tobacco counseling, control/prevention oral disease	NPB	\$0		
D1330	Oral hygiene instruction	\$0	\$0		
D1351	Sealant, per tooth	\$10	NPB	1 of (D1351, D1352) per tooth, 1st and 2nd permanent molars per lifetime	
D1352	Preventive resin restoration, permanent tooth	\$10	NPB		



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Preventive Services (continued)					
D1353	Sealant repair, per tooth	\$10	NPB	1 (D1353) per tooth, 1st and 2nd permanent molars per lifetime	
D1510	Space maintainer, fixed, unilateral, per quadrant	\$85	NPB	2 of (D1510-D1527, D1575) every 12 months, 4 units per lifetime	
D1516	Space maintainer, fixed, bilateral, maxillary	\$85	NPB		
D1517	Space maintainer, fixed, bilateral, mandibular	\$85	NPB		
D1520	Space maintainer, removable, unilateral, per quadrant	\$85	NPB		
D1526	Space maintainer, removable, bilateral, maxillary	\$85	NPB		
D1527	Space maintainer, removable, bilateral, mandibular	\$85	NPB		
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	\$10	NPB		
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	\$10	NPB		
D1553	Re-cement or re-bond unilateral space maintainer, mandibular	\$10	NPB		
D1556	Removal of fixed unilateral space maintainer, per quadrant	\$10	NPB		
D1557	Removal of fixed unilateral space maintainer, maxillary	\$10	NPB		
D1558	Removal of fixed unilateral space maintainer, mandibular	\$10	NPB		
D1575	Distal shoe space maintainer, fixed, per quadrant	\$85	NPB	2 of (D1510-D1527, D1575) every 12 months, 4 units per lifetime	
Basic Restorative Services					
D2140	Amalgam, one surface, primary or permanent	\$51	\$10	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months, if replacement restoration is less than 12 months by the same dental office or provider it is not chargeable to the plan or member	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months, if replacement restoration is less than 12 months by the same dental office or provider it is not chargeable to the plan or member
D2150	Amalgam, two surfaces, primary or permanent	\$65	\$15		
D2160	Amalgam, three surfaces, primary or permanent	\$79	\$20		
D2161	Amalgam, four or more surfaces, primary or permanent	\$96	\$25		
D2330	Resin-based composite, one surface, anterior	\$60	\$10		
D2331	Resin-based composite, two surfaces, anterior	\$77	\$15		
D2332	Resin-based composite, three surfaces, anterior	\$85	\$20		
D2335	Resin-based composite, four or more surfaces, involving incisal angle	\$98	\$25		
D2390	Resin-based composite crown, anterior	\$150	\$100	1 (D2390) per tooth every 12 months	1 (D2390) per tooth every 12 months
D2391	Resin-based composite, one surface, posterior	\$55	\$20	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months, if replacement restoration is less than 12 months by the same dental office or provider it is not chargeable to the plan or member	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months, if replacement restoration is less than 12 months by the same dental office or provider it is not chargeable to the plan or member
D2392	Resin-based composite, two surfaces, posterior	\$75	\$25		
D2393	Resin-based composite, three surfaces, posterior	\$90	\$30		
D2394	Resin-based composite, four or more surfaces, posterior	\$105	\$35		
Major Restorative Services					
*GUIDELINE CROWNS-PEDIATRIC ONLY					
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. Posterior teeth: 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.					
D2510	Inlay, metallic, one surface	NPB	\$250	1 of (D2510-D2794, D6205-D6794) per permanent tooth every 5 year period. Must meet medical necessity as determined by a dentist	
D2520	Inlay, metallic, two surfaces	NPB	\$250		
D2530	Inlay, metallic, three or more surfaces	NPB	\$250		
D2542	Onlay, metallic, two surfaces	NPB	\$250		
D2543	Onlay, metallic, three surfaces	NPB	\$250		
D2544	Onlay, metallic, four or more surfaces	NPB	\$250		
D2610	Inlay, porcelain/ceramic, one surface	NPB	\$250		
D2620	Inlay, porcelain/ceramic, two surfaces	NPB	\$250		
D2630	Inlay, porcelain/ceramic, three or more surfaces	NPB	\$250		
D2642	Onlay, porcelain/ceramic, two surfaces	NPB	\$250		
D2643	Onlay, porcelain/ceramic, three surfaces	NPB	\$250		
D2644	Onlay, porcelain/ceramic, four or more surfaces	NPB	\$250		
D2650	Inlay, resin-based composite, one surface	NPB	\$250		
D2651	Inlay, resin-based composite, two surfaces	NPB	\$250		
D2652	Inlay, resin-based composite, three or more surfaces	NPB	\$250		
D2662	Onlay, resin-based composite, two surfaces	NPB	\$250		
D2663	Onlay, resin-based composite, three surfaces	NPB	\$250		



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Major Restorative Services (continued)					
D2664	Onlay, resin-based composite, four or more surfaces	NPB	\$250		
D2710	Crown, resin-based composite (indirect)	NPB	\$150		
D2712	Crown, ¾ resin-based composite (indirect)	\$320	\$150		
D2720	Crown, resin with high noble metal	NPB	\$150		
D2721	Crown, resin with predominantly base metal	\$350*	\$150		
D2722	Crown, resin with noble metal	NPB	\$150		
D2740	Crown, porcelain/ceramic	\$350*	\$150		
D2750	Crown, porcelain fused to high noble metal	NPB	\$200		
D2751	Crown, porcelain fused to predominantly base metal	\$350*	\$200	1 of (D2712-D2791) per permanent tooth every 5 year period. Must meet medical necessity as determined by a dentist	1 of (D2510-D2794, D6205-D6794) per permanent tooth every 5 year period. Must meet medical necessity as determined by a dentist
D2752	Crown, porcelain fused to noble metal	NPB	\$200		
D2780	Crown, ¾ cast high noble metal	NPB	\$200		
D2781	Crown, ¾ cast predominantly base metal	\$350*	\$200		
D2782	Crown, ¾ cast noble metal	NPB	\$200		
D2783	Crown, ¾ porcelain/ceramic	NPB	\$200		
D2790	Crown, full cast high noble metal	NPB	\$200		
D2791	Crown, full cast predominantly base metal	\$350*	\$200		
D2792	Crown, full cast noble metal	NPB	\$200		
D2794	Crown, titanium and titanium alloys	NPB	\$300		
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$20	\$20		
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$20	\$20		
D2920	Re-cement or re-bond crown	\$20	\$20		
D2921	Reattachment of tooth fragment, incisal edge or cuspal	NPB	\$25		
D2930	Prefabricated stainless steel crown, primary tooth	\$72	\$50	1 (D2930) per tooth every 36 months	1 (D2930) per tooth every 36 months
D2931	Prefabricated stainless steel crown, permanent tooth	\$100	\$75	1 (D2931) per tooth per lifetime	1 (D2931) per tooth per lifetime
D2932	Prefabricated resin crown	\$80	\$75	1 (D2932) per tooth every 36 months	1 (D2932) per tooth every 36 months
D2933	Prefabricated stainless steel crown with resin window	\$115	\$50	1 (D2933) per tooth every 36 months	1 (D2933) per tooth every 36 months
D2940	Protective restoration	\$30	\$30		
D2949	Restorative foundation for an indirect restoration	NPB	\$85		
D2950	Core buildup, including any pins when required	\$100	\$100		
D2951	Pin retention, per tooth, in addition to restoration	\$20	\$20		
D2952	Post and core in addition to crown, indirectly fabricated	\$115	\$115		
D2953	Each additional indirectly fabricated post, same tooth	\$85	\$85		
D2954	Prefabricated post and core in addition to crown	\$90	\$90		
D2955	Post removal	\$85	\$85		
D2957	Each additional prefabricated post, same tooth	\$72	\$72		
D2960	Labial veneer (resin laminate), chairside	\$310	\$125		
D2961	Labial veneer (resin laminate), laboratory	\$335	\$150		
D2962	Labial veneer (porcelain laminate), laboratory	\$355	\$150	1 of (D2960-D2962) per permanent tooth when medically necessary	1 of (D2960-D2962) per permanent tooth every 5 year period
D2971	Additional procedure to construct new crown, existing partial denture frame	NPB	\$30		
D2975	Coping	\$100	\$100		
D2980	Crown repair necessitated by restorative material failure	\$85	\$85		
D2981	Inlay repair necessitated by restorative material failure	NPB	\$85		
D2982	Onlay repair necessitated by restorative material failure	NPB	\$85		
D2983	Veneer repair necessitated by restorative material failure	NPB	\$85		
Endodontic Services					
D3110	Pulp cap, direct (excluding final restoration)	\$20	\$20		
D3120	Pulp cap, indirect (excluding final restoration)	\$20	\$20		
D3220	Therapeutic pulpotomy (excluding final restoration)	\$65	\$65		
D3221	Pulpal debridement, primary and permanent teeth	NPB	\$35		
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	\$70	\$70		



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Endodontic Services (continued)					
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$80	\$80		
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	\$90	\$90		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$200	\$100		
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$250	\$150		
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$350	\$200		
D3331	Treatment of root canal obstruction; non-surgical access	\$95	\$95		
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	\$200	\$200		
D3333	Internal root repair of perforation defects	NPB	\$35		
D3346	Retreatment of previous root canal therapy, anterior	NPB	\$150		
D3347	Retreatment of previous root canal therapy, premolar	NPB	\$200		
D3348	Retreatment of previous root canal therapy, molar	NPB	\$250		
D3351	Apexification/recalcification, initial visit	\$85	\$85		
D3352	Apexification/recalcification, interim medication replacement	\$85	\$85		
D3353	Apexification/recalcification, final visit	\$150	\$150		
D3410	Apicoectomy, anterior	\$185	\$185		
D3421	Apicoectomy, premolar (first root)	\$254	\$254		
D3425	Apicoectomy, molar (first root)	\$275	\$275		
D3426	Apicoectomy, (each additional root)	\$75	\$75		
D3427	Periradicular surgery without apicoectomy	\$300	\$300		
D3430	Retrograde filling, per root	\$75	\$75		
D3450	Root amputation, per root	\$110	\$110		
D3460	Endodontic endosseous implant	\$320	NPB		
D3920	Hemisection, not including root canal therapy	\$85	\$85		
D3950	Canal preparation and fitting of preformed dowel or post	\$70	NPB		
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$125	\$125	1 of (D4210-D4278) surgical procedure per quad every 60 months	1 of (D4210-D4285) surgical procedure per quad every 60 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$45	\$45		
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	NPB	\$75		
D4230	Anatomical crown exposure, four or more teeth per quadrant	\$189	NPB		
D4231	Anatomical crown exposure, one to three teeth per quadrant	\$170	NPB		
D4240	Gingival flap procedure, four or more teeth per quadrant	\$125	\$125		
D4241	Gingival flap procedure, one to three teeth per quadrant	\$95	\$95		
D4245	Apically positioned flap	NPB	\$20		
D4249	Clinical crown lengthening, hard tissue	\$210	\$210		
D4260	Osseous surgery, four or more teeth per quadrant	\$205	\$205		
D4261	Osseous surgery, one to three teeth per quadrant	\$165	\$165		
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	\$195	\$195		
D4264	Bone replacement graft, retained natural tooth, each additional site	\$150	\$150		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	\$100	NPB		
D4266	Guided tissue regeneration, resorbable barrier, per site	\$300	\$300		
D4267	Guided tissue regeneration, non-resorbable barrier, per site	\$350	\$350		
D4270	Pedicle soft tissue graft procedure	\$125	\$125		
D4273	Autogenous connective tissue graft procedure, first tooth	\$350	\$350		
D4274	Mesial/distal wedge procedure, single tooth	\$210	\$210		
D4275	Non-autogenous connective tissue graft, first tooth	NPB	\$350		
D4277	Free soft tissue graft, first tooth	\$340	\$615		
D4278	Free soft tissue graft, each additional tooth	\$350	\$205		
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	NPB	\$350		
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	NPB	\$350		
D4320	Provisional splinting, intracoronal	\$50	NPB		
D4321	Provisional splinting, extracoronal	\$70	NPB		



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Periodontal Services (continued)					
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	\$110	\$40	1 of (D4341, D4342) per site/quad every 12 months	1 of (D4341, D4342) per site/quad every 12 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$60	\$25		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$10	\$25	2 of (D1110, D1120, D4346, D4910) per plan year	2 of (D1110, D4346, D4910) per plan year
D4355	Full mouth debridement	\$75	\$25		
D4381	Localized delivery of antimicrobial agent/per tooth	\$70	\$25		1 (D4355) every 24 months
D4910	Periodontal maintenance	\$42	\$0	2 of (D1110, D1120, D4346, D4910) per plan year	2 of (D1110, D4346, D4910) per plan year
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	\$350	\$400	1 of (D5110-D5214, D5282, D5283) per arch every 60 months. Must meet medical necessity as determined by a dentist	1 of (D5110-D5226, D5282, D5283) per arch every 60 months. Must meet medical necessity as determined by a dentist
D5120	Complete denture, mandibular	\$350	\$400		
D5130	Immediate denture, maxillary	\$350	\$450		
D5140	Immediate denture, mandibular	\$350	\$450		
D5211	Maxillary partial denture, resin base	\$350	\$150		
D5212	Mandibular partial denture, resin base	\$350	\$150		
D5213	Maxillary partial denture, cast metal, resin base	\$350	\$400		
D5214	Mandibular partial denture, cast metal, resin base	\$350	\$400		
D5221	Immediate maxillary partial denture, resin base	NPB	\$250		
D5222	Immediate mandibular partial denture, resin base	NPB	\$250		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	NPB	\$400		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	NPB	\$400		
D5225	Maxillary partial denture, flexible base	NPB	\$300		
D5226	Mandibular partial denture, flexible base	NPB	\$300		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	\$350	\$300	1 of (D5110-D5214, D5282, D5283) per arch every 60 months. Must meet medical necessity as determined by a dentist	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	\$350	\$300		
D5410	Adjust complete denture, maxillary	\$45	\$30	1 of (D5410-D5422) per arch every 6 months	1 of (D5410-D5422) per arch every 6 months
D5411	Adjust complete denture, mandibular	\$45	\$30		
D5421	Adjust partial denture, maxillary	\$45	\$30		
D5422	Adjust partial denture, mandibular	\$45	\$30		
D5511	Repair broken complete denture base, mandibular	\$65	\$40		
D5512	Repair broken complete denture base, maxillary	\$65	\$40		
D5520	Replace missing or broken teeth, complete denture	\$41	\$30		
D5611	Repair resin partial denture base, mandibular	\$65	\$40		
D5612	Repair resin partial denture base, maxillary	\$65	\$40		
D5621	Repair cast partial framework, mandibular	\$125	\$75		
D5622	Repair cast partial framework, maxillary	\$125	\$75		
D5630	Repair or replace broken retentive clasping, per tooth	\$125	\$75		
D5640	Replace broken teeth, per tooth	\$65	\$65		
D5650	Add tooth to existing partial denture	\$65	\$65		
D5660	Add clasp to existing partial denture, per tooth	\$105	\$105		
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	\$310	\$310		
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	\$310	\$310		
D5710	Rebase complete maxillary denture	NPB	\$100		
D5711	Rebase complete mandibular denture	NPB	\$100		
D5720	Rebase maxillary partial denture	NPB	\$100		
D5721	Rebase mandibular partial denture	NPB	\$100		
D5730	Reline complete maxillary denture, chairside	\$125	\$100	1 of (D5730-D5761) per arch every 6 months	1 of (D5730-D5761) per arch every 6 months
D5731	Reline complete mandibular denture, chairside	\$125	\$100		
D5740	Reline maxillary partial denture, chairside	\$105	\$100		
D5741	Reline mandibular partial denture, chairside	\$105	\$100		
D5750	Reline complete maxillary denture, laboratory	\$190	\$100		



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Removable Prosthodontic Services (continued)					
D5751	Reline complete mandibular denture, laboratory	\$190	\$100	1 of (D5730-D5761) per arch every 6 months	1 of (D5730-D5761) per arch every 6 months
D5760	Reline maxillary partial denture, laboratory	\$165	\$100		
D5761	Reline mandibular partial denture, laboratory	\$165	\$100		
D5820	Interim partial denture, maxillary	\$205	\$205	1 of (D5820, D5821) per arch every 60 months. Must meet medical necessity as determined by a dentist	1 of (D5820, D5821) per arch every 60 months. Must meet medical necessity as determined by a dentist
D5821	Interim partial denture, mandibular	\$205	\$205		
D5850	Tissue conditioning, maxillary	\$42	\$42		
D5851	Tissue conditioning, mandibular	\$42	\$42		
D5862	Precision attachment, by report	\$185	NPB		
Fixed Prosthodontic Services					
D6205	Pontic, indirect resin based composite	NPB	\$292		1 of (D2510-D2794, D6205-D6794) per permanent tooth every 5 year period. Must meet medical necessity as determined by a dentist
D6210	Pontic, cast high noble metal	NPB	\$200		
D6211	Pontic, cast predominantly base metal	NPB	\$200		
D6212	Pontic, cast noble metal	NPB	\$200		
D6214	Pontic, titanium, and titanium alloys	NPB	\$200		
D6240	Pontic, porcelain fused to high noble metal	NPB	\$200		
D6241	Pontic, porcelain fused to predominantly base metal	NPB	\$200		
D6242	Pontic, porcelain fused to noble metal	NPB	\$200		
D6245	Pontic, porcelain/ceramic	NPB	\$200		
D6250	Pontic, resin with high noble metal	NPB	\$200		
D6251	Pontic, resin with predominantly base metal	NPB	\$200		
D6252	Pontic, resin with noble metal	NPB	\$200		
D6600	Retainer inlay, porcelain/ceramic, two surfaces	NPB	\$380		
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	NPB	\$380		
D6602	Retainer inlay, cast high noble metal, two surfaces	NPB	\$380		
D6603	Retainer inlay, cast high noble metal, three or more surfaces	NPB	\$380		
D6604	Retainer inlay, cast base metal, two surfaces	NPB	\$380		
D6605	Retainer inlay, cast base metal, three or more surfaces	NPB	\$380		
D6606	Retainer inlay, cast noble metal, two surfaces	NPB	\$380		
D6607	Retainer inlay, cast noble metal, three or more surfaces	NPB	\$380		
D6608	Retainer onlay, porcelain/ceramic, two surfaces	NPB	\$380		
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	NPB	\$380		
D6610	Retainer onlay, cast high noble metal, two surfaces	NPB	\$380		
D6611	Retainer onlay, cast high noble metal, three or more surfaces	NPB	\$380		
D6612	Retainer onlay, cast base metal, two surfaces	NPB	\$380		
D6613	Retainer onlay, cast base metal, three or more surfaces	NPB	\$380		
D6614	Retainer onlay, cast noble metal, two surfaces	NPB	\$380		
D6615	Retainer onlay, cast noble metal three or more surfaces	NPB	\$380		
D6710	Retainer crown, indirect resin based composite	NPB	\$285		
D6720	Retainer crown, resin with high noble metal	NPB	\$300		
D6721	Retainer crown, resin with predominantly base metal	NPB	\$300		
D6722	Retainer crown, resin with noble metal	NPB	\$300		
D6740	Retainer crown, porcelain/ceramic	NPB	\$300		
D6750	Retainer crown, porcelain fused to high noble metal	NPB	\$300		
D6751	Retainer crown, porcelain fused to predominantly base metal	NPB	\$300		
D6752	Retainer crown, porcelain fused to noble metal	NPB	\$300		
D6780	Retainer crown, ¼ cast high noble metal	NPB	\$300		
D6781	Retainer crown, ¼ cast predominantly base metal	NPB	\$300		
D6782	Retainer crown, ¼ cast noble metal	NPB	\$300		
D6783	Retainer crown, ¼ porcelain/ceramic	NPB	\$300		
D6790	Retainer crown, full cast high noble metal	NPB	\$300		



NV Family Plus Dental Plan

Individual Out of Pocket Maximum: \$350 (applies to Pediatric only)

Family Out of Pocket Maximum: \$700 (applies to Pediatric only)

ADA Code	Description	Pediatric Copay	Adult Copay	Pediatric Limitations	Adult Limitation
Fixed Prosthodontic Services (continued)					
D6791	Retainer crown, full cast predominantly base metal	NPB	\$300		1 of (D2510-D2794, D6205-D6794) per permanent tooth every 5 year period. Must meet medical necessity as determined by a dentist
D6792	Retainer crown, full cast noble metal	NPB	\$300		
D6794	Retainer crown, titanium and titanium alloys	NPB	\$350		
D6930	Re-cement or re-bond fixed partial denture	\$75	\$75		
D6940	Stress breaker	NPB	\$93		
D6980	Fixed partial denture repair, restorative material failure	NPB	\$20		
Oral & Maxillofacial Services					
D7111	Extraction, coronal remnants, primary tooth	\$42	\$15		
D7140	Extraction, erupted tooth or exposed root	\$45	\$20		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	\$90	\$25		
D7220	Removal of impacted tooth, soft tissue	\$130	\$30		
D7230	Removal of impacted tooth, partially bony	\$125	\$40		
D7240	Removal of impacted tooth, completely bony	\$150	\$55		
D7241	Removal impacted tooth, complete bony, complication	\$205	\$55		
D7250	Removal of residual tooth roots (cutting procedure)	\$85	\$85		
D7251	Coronectomy, intentional partial tooth removal	NPB	\$65		
D7260	Oroantral fistula closure	\$250	NPB		
D7261	Primary closure of a sinus perforation	\$290	NPB		
D7270	Tooth reimplantation and/or stabilization, accident	\$105	\$105		
D7280	Exposure of an unerupted tooth	\$125	\$125		
D7282	Mobilization of erupted/malpositioned tooth	NPB	\$125		
D7283	Placement, device to facilitate eruption, impaction	\$50	\$50		
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$95	NPB		
D7286	Incisional biopsy of oral tissue, soft	\$85	\$85		
D7287	Exfoliative cytological sample collection	\$45	NPB		
D7288	Brush biopsy, transepithelial sample collection	\$50	NPB		
D7290	Surgical repositioning of teeth	\$250	NPB		
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$78	NPB		
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap	\$350	NPB		
D7293	Placement of temporary anchorage device requiring flap; includes device removal	\$350	NPB		
D7294	Placement of temporary anchorage device without flap; includes device removal	\$350	NPB		
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$90	\$90		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$110	\$110		
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$110	\$110		
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$160	\$160		
D7410	Excision of benign lesion, up to 1.25 cm	\$105	NPB		
D7411	Excision of benign lesion, greater than 1.25 cm	\$105	NPB		
D7412	Excision of benign lesion, complicated	\$160	NPB		
D7440	Excision of malignant tumor, up to 1.25 cm	\$30	NPB		
D7441	Excision of malignant tumor, greater than 1.25 cm	\$60	NPB		
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	\$205	\$205		
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	\$330	\$330		
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	\$205	NPB		
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	\$330	NPB		
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$110	NPB		
D7471	Removal of lateral exostosis, maxilla or mandible	NPB	\$150		
D7472	Removal of torus palatinus	\$150	\$150		
D7473	Removal of torus mandibularis	\$150	\$150		
D7490	Radical resection of maxilla or mandible	\$350	NPB		
D7510	Incision & drainage of abscess, intraoral soft tissue	\$82	\$82		



NV Family Plus Dental Plan

Individual Out of Pocket Maximum: \$350 (applies to Pediatric only)

Family Out of Pocket Maximum: \$700 (applies to Pediatric only)

ADA Code	Description	Pediatric Copay	Adult Copay	Pediatric Limitations	Adult Limitation
Oral & Maxillofacial Services (continued)					
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	\$95	NPB		
D7520	Incision & drainage of abscess, extraoral soft tissue	\$125	NPB		
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	\$150	NPB		
D7530	Remove foreign body, mucosa, skin, tissue	\$90	NPB		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$125	NPB		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$350	NPB		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$275	NPB		
D7610	Maxilla, open reduction (teeth immobilized, if present)	\$350	NPB		
D7620	Maxilla, closed reduction (teeth immobilized, if present)	\$350	NPB		
D7630	Mandible, open reduction (teeth immobilized, if present)	\$350	NPB		
D7640	Mandible, closed reduction (teeth immobilized, if present)	\$350	NPB		
D7650	Malar and/or zygomatic arch, open reduction	\$350	NPB		
D7660	Malar and/or zygomatic arch, closed reduction	\$350	NPB		
D7670	Alveolus, closed reduction, may include stabilization of teeth	\$350	NPB		
D7671	Alveolus, open reduction, may include stabilization of teeth	\$350	NPB		
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	\$350	NPB		
D7710	Maxilla, open reduction	\$350	NPB		
D7720	Maxilla, closed reduction	\$350	NPB		
D7730	Mandible, open reduction	\$350	NPB		
D7740	Mandible, closed reduction	\$350	NPB		
D7750	Malar and/or zygomatic arch, open reduction	\$350	NPB		
D7760	Malar and/or zygomatic arch, closed reduction	\$350	NPB		
D7770	Alveolus, open reduction stabilization of teeth	\$350	NPB		
D7771	Alveolus, closed reduction stabilization of teeth	\$350	NPB		
D7780	Facial bones, complicated reduction with fixation and multiple approaches	\$350	NPB		
D7910	Suture of recent small wounds up to 5 cm	\$30	NPB		
D7911	Complicated suture, up to 5 cm	\$55	NPB		
D7912	Complicated suture, greater than 5 cm	\$15	NPB		
D7940	Osteoplasty, for orthognathic deformities	\$350	NPB		
D7941	Osteotomy, mandibular rami	\$350	NPB		
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	\$350	NPB		
D7944	Osteotomy, segmented or subapical	\$350	NPB		
D7945	Osteotomy, body of mandible	\$350	NPB		
D7946	LeFort I (maxilla, total)	\$350	NPB		
D7947	LeFort I (maxilla, segmented)	\$350	NPB		
D7948	LeFort II or LeFort III, without bone graft	\$350	NPB		
D7949	LeFort II or LeFort III, with bone graft	\$350	NPB		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$350	NPB		
D7953	Bone replacement graft for ridge preservation, per site	\$350	NPB		
D7955	Repair of maxillofacial soft and/or hard tissue defect	\$350	NPB		
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	\$125	\$125		
D7963	Frenuloplasty	\$150	NPB		
D7970	Excision of hyperplastic tissue, per arch	\$250	\$250		
D7971	Excision of pericoronal gingiva	\$125	\$125		
D7980	Surgical sialolithotomy	\$250	NPB		
D7981	Excision of salivary gland, by report	\$350	NPB		
D7982	Sialodochoplasty	\$350	NPB		
D7983	Closure of salivary fistula	\$250	NPB		
D7990	Emergency tracheotomy	\$350	NPB		
D7991	Coronoidectomy	\$350	NPB		



NV Family Plus Dental Plan

Individual Out of Pocket Maximum: \$350 (applies to Pediatric only)

Family Out of Pocket Maximum: \$700 (applies to Pediatric only)

ADA Code	Description	Pediatric Copay	Adult Copay	Pediatric Limitations	Adult Limitation
Oral & Maxillofacial Services (continued)					
D7996	Implant-mandible for augmentation purposes, by report	\$350	NPB		
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	\$350	NPB		
Orthodontic Services					
GUIDELINE: For Pediatric Dental EHB, 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 qualifying conditions) on HLD Index analysis. All treatment must be prior authorized by the Plan prior to banding.					
<i>All copayments paid by the enrollee, including orthodontic copayments, apply towards the annual Out of Pocket Maximum.</i>					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$350	NPB		
D8090	Comprehensive orthodontic treatment of the adult dentition	\$350	NPB		
<i>*\$350 copayment per plan year, not to exceed \$1700 over the course of treatment. (D8090 refer to a usual and customary 24-month course of orthodontic treatment, with treatment progressing and offered regularly at intervals determined to be appropriate by the treating dentist.)</i>					
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$50	NPB		
D8670	Periodic orthodontic treatment visit	\$80	NPB		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$120	NPB		
D8690	Orthodontic treatment (alternative billing to a contract fee)	\$92	NPB		
D8698	Re-cement or re-bond fixed retainer, maxillary	\$70	NPB		
D8699	Re-cement or re-bond fixed retainer, mandibular	\$70	NPB		
D8701	Repair of fixed retainer, includes reattachment, maxillary	\$70	NPB		
D8702	Repair of fixed retainer, includes reattachment, mandibular	\$70	NPB		
Adjunctive General Services					
D9110	Palliative (emergency) treatment, minor procedure	\$10	\$34		
D9120	Fixed partial denture sectioning	\$65	\$65		
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$15	\$15		
D9212	Trigeminal division block anesthesia	\$15	\$15		
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0	\$0		
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	\$50	\$50		
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	\$50	\$50		
D9230	Inhalation of nitrous oxide/analgesia, anxiety	\$20	\$20		
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	\$15	\$15		
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	\$15	\$15		
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	\$100	\$100		
D9310	Consultation, other than requesting dentist	\$70	\$70		
D9410	House/extended care facility call	\$70	\$70		
D9420	Hospital or ambulatory surgical center call	\$45	\$45		
D9430	Office visit, observation, regular hours, no other services	\$25	\$25		
D9440	Office visit, after regularly scheduled hours	\$60	\$60		
D9610	Therapeutic parenteral drug, single administration	\$30	\$30		
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	\$45	\$45		
D9630	Drugs or medicaments dispensed in the office for home use	\$5	\$5		
D9930	Treatment of complications, post surgical, unusual, by report	\$35	\$35		
D9932	Cleaning and inspection of removable complete denture, maxillary	\$0	NPB		
D9933	Cleaning and inspection of removable complete denture, mandibular	\$0	NPB		
D9934	Cleaning and inspection of removable partial denture, maxillary	\$0	NPB		
D9935	Cleaning and inspection of removable partial denture, mandibular	\$0	NPB		
D9942	Repair and/or reline of occlusal guard	\$75	\$75		
D9943	Occlusal guard adjustment	NPB	\$15		
D9944	Occlusal guard, hard appliance, full arch	\$215	\$215		
D9945	Occlusal guard, soft appliance, full arch	\$215	\$215		



NV Family Plus Dental Plan

Individual Out of Pocket Maximum: \$350 (applies to Pediatric only)

Family Out of Pocket Maximum: \$700 (applies to Pediatric only)

ADA Code	Description	Pediatric Copay	Adult Copay	Pediatric Limitations	Adult Limitation
Adjunctive General Services (continued)					
D9946	Occlusal guard, hard appliance, partial arch	\$215	\$215		
D9950	Occlusion analysis, mounted case	\$170	\$170		
D9951	Occlusal adjustment, limited	\$15	\$15		
D9952	Occlusal adjustment, complete	\$165	\$165		

NPB Not Plan Benefit

Eligibility – Pediatric Benefits – Children through the age of 18

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 Member Service department at 888-700-1246 for instruction on how to submit. Proof that the Out-of-Pocket Maximum has been reached must be submitted to LIBERTY Dental Plan.

NV Family Plus Dental Plan

Exclusions:

- 1 Any procedure not specifically listed as a Covered Benefit.
- 2 Replacement of lost or stolen prosthetics or appliances including partial dentures, full dentures, and orthodontic appliances.
- 3 General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits.
- 4 Treatment started prior to coverage or after termination of coverage.
- 5 Services for cosmetic purposes or for conditions that are a result of hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
- 6 Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
- 7 Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
- 8 Any service performed outside of a contracted LIBERTY dental office, unless expressly authorized by LIBERTY, or unless as outlined and covered in the "Emergency Dental Care" section of the Evidence of Coverage.
- 9 The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
- 10 Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
- 11 Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces or teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting.
- 12 Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
- 13 Consultations for non-covered services.
- 14 Procedures, appliances or restorations to treat congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to; myofunctional treatment (e.g. speech therapy) or myoskeletal dysfunctions, unless otherwise covered as an orthodontic benefit.

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

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

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

If you need these services, please contact us at 1-888-401-1128.

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Online at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

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

Notice of Language Assistance

If you, or someone you support, have questions about LIBERTY Dental Plan, you have the right to get help and information in your language at no cost. To speak to an interpreter, call 1-888-401-1128.

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ LIBERTY Dental Plan ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-888-401-1128 ይደውሉ። (Amharic)

إذا كان لديك أو شخص ما تساعده أية استفسارات عن LIBERTY Dental Plan لديك الحق في تلقي المساعدة والمعلومات بلغتك مجاناً. للتحدث إلى مترجم فوري، اتصل على الرقم 1-888-401-1128 (Arabic)

如果您，或您正在幫助的人，有關於LIBERTY Dental Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電 1-888-401-1128. (Chinese)

اگر شما یا شخصی که به وی کمک می کنید، سوالاتی در مورد LIBERTY Dental Plan دارید، شما حق دارید که کمک و اطلاعات را به زبان خودتان و به طور رایگان دریافت کنید. برای گفتگو با مترجم شفاهی، با شماره تماس بگیرید 1-888-401-1128 (Farsi)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de LIBERTY Dental Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-401-1128. (French)

Falls Sie oder jemand, dem Sie helfen, Fragen zum LIBERTY Dental Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-401-1128 an. (German)

No dakayo, wenna maysa a tao a tultulunganyo, ket adda kayatyo a saludsoden maipanggep iti LIBERTY Dental Plan, adda karbenganyo a dumawat iti tulong ken impormasion iti bukodyo a pagsasao nga awan ti bayadanyo. Tapno makipatang iti maysa a mangipatarus iti pagsasao, tumawag iti numero nga 1-888-401-1128. (Ilocano)

ご本人様、またはお客様の身の回りの方でもLIBERTY Dental Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合1-888-401-1128までお電話ください (Japanese)

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 LIBERTY Dental Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-401-1128 로 전화하십시오. (Korean)

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу LIBERTY Dental Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-401-1128. (Russian)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de LIBERTY Dental Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-401-1128. (Spanish)

‘Afa’i olo’o iai se fesili iate oe, po o se tasi olo’o e fesoasoani i ai, e uiga i le LIBERTY Dental Plan polokalame, o iai iate oe le aia tatau e maua atu ai i se fesoasoani po o se fa’atamalaga e uiga i lena polokalame i le gagana fa’asamoā, auno ma se togiga o tupe. Ina ia talatalanoa i se tagata ua malamalama ai i le gagana fa’asoma, po o se tagata fa’aliliu gagana, vili atu e lau telefoni 1-888-401-1128. (Samoan)

Notice of Language Assistance

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa LIBERTY Dental Plan may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-401-1128. (Tagalog)

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ LIBERTY Dental Plan,

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-401-1128. (Thai)

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về LIBERTY Dental Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-401-1128. (Vietnamese)