



LIBERTY Dental Plan CA50 COPAYMENT SCHEDULE

Code	Description	Member Copayment	Code	Description	Member Copayment
Diagnostic Services					
D0120	Periodic Oral Evaluation	0	D2782	Crown, ¾ Cast Noble Metal*	195
D0140	Limited Oral Evaluation	0	D2790	Crown, Full Cast Hi Noble Metal*	195
D0150	Comprehensive Oral Evaluation	0	D2791	Crown, Full Cast Base Metal*	195
D0210	Full Mouth X-rays	0	D2792	Crown, Full Cast Noble Metal*	195
D0220	Periapical X-ray – first film	0	D2794	Crown, Titanium*	195
D0230	Periapical X-ray – additional film	0	D2910	Recement Inlay	0
D0240	Occlusal film	0	D2920	Recement Crown	0
D0250	Extra-oral X-ray – first film	0	D2930	Prefab. Stain. St. Crown, Primary	50
D0260	Extra-oral X-ray – additional film	0	D2931	Prefab. Stain St. Crown, Perm.	50
D0270	Bitewing X-ray – single film	0	D2940	Sedative Filling	0
D0272	Bitewing X-ray – two films	0	D2950	Core Buildup, Inc. Pins	50
D0274	Bitewing X-ray – four films	0	D2951	Pin Retention	15
D0330	Panoramic Film	0	D2952	Cast Post & Core*	50
D0460	Pulp Vitality Test	0	D2954	Prefab. Post & Core	45
D0470	Diagnostic Casts	0	D2955	Post Removal	10
Preventive Services					
D1110	Prophylaxis – Adult	9	D3110	Pulp Cap, Direct	5
D1120	Prophylaxis – Child	9	D3120	Pulp Cap, Indirect	5
D1201	Prophylaxis with Fluoride – Child	9	D3220	Therapeutic Pulpotomy	20
D1203	Fluoride w/o Prophylaxis – Child	9	D3230	Pulpal Therapy, Primary Anterior	40
D1204	Fluoride w/o Prophylaxis – Adult	9	D3240	Pulpal Therapy, Primary Posterior	40
D1205	Prophylaxis with Fluoride – Adult	9	D3310	Root Canal, Anterior	110
D1330	Oral Hygiene Instruction	0	D3320	Root Canal, Bicuspid	120
D1351	Sealant – Per Tooth	10	D3330	Root Canal, Molar	265
D1510	Space Maint. Fixed Unilateral	50	D3346	Retreat Root Canal, Anterior	110
D1515	Space Maint. Fixed Bilateral	50	D3347	Retreat Root Canal, Bicuspid	130
D1520	Space Maint. Remov. Unilateral	50	D3348	Retreat Root Canal, Molar	275
D1525	Space Maint. Remov. Bilateral	50	D3351	Apex./Recal. – Initial Visit	65
D1550	Recement Space Maintainer	0	D3352	Apex./Recal. – Interim Visit	65
Restorative Services					
D2140	Amalgam, 1 Surface	11	D3353	Apex./Recal. – Final Visit	65
D2150	Amalgam, 2 Surface	13	D3410	Apicoectomy, Anterior	150
D2160	Amalgam, 3 Surface	15	D3421	Apicoectomy, Bicuspid 1 st Root	150
D2161	Amalgam, 4 Surface	17	D3425	Apicoectomy, Molar 1 st Root	150
D2330	Resin Comp., 1 Surface Anterior	15	D3426	Apicoectomy, Each Add. Root	100
D2331	Resin Comp., 2 Surface Anterior	18	D3430	Retrograde Filling, Per Root	30
D2332	Resin Comp., 3 Surface Anterior	23	D3450	Root Amputation, Per Root	95
D2335	Resin Comp., 4 Surface Anterior	25	D3920	Hemisection, Not Incl. Root Canal	90
D2390	Resin Comp. Crown, Anterior	30	Periodontic Services		
D2391	Resin Comp., 1 Surface Posterior	50	D4210	Gingivectomy, 4+ Teeth per Quad.	125
D2392	Resin Comp., 2 Surface Posterior	70	D4211	Gingivectomy, 1-3 Teeth per Quad.	16
D2393	Resin Comp., 3 Surface Posterior	120	D4240	Ging. Flap Proc., 4+ Teeth per Quad.	250
D2510	Inlay, Metallic, 1 Surface*	170	D4241	Ging. Flap Proc., 1-3 Teeth per Quad.	250
D2520	Inlay, Metallic, 2 Surface*	170	D4260	Osseous Surg., 4+ Teeth per Quad.	250
D2530	Inlay, Metallic, 3 or More Surfaces*	170	D4261	Osseous Surg., 1-3 Teeth per Quad.	250
D2543	Onlay, Metallic, 3 Surfaces*	195	D4341	Scale & Root Plan, 4+ Teeth per Quad	50
D2544	Onlay, Metallic, 4 or More Surfaces*	195	D4342	Scale & Root Plan, 1-3 Teeth per Quad	50
Crowns					
D2740	Crown, Porc./Ceramic Substrate	225	D4355	Full Mouth Debridement	40
D2750	Crown, Porc./Hi Noble Metal*	195	D4910	Perio. Maint. Procedure	40
D2751	Crown, Porc./Base Metal*	195	Removable Prosthodontics		
D2752	Crown, Porc./Noble Metal*	195	D5110	Complete Upper Denture	250
D2780	Crown, ¾ Cast Hi Noble Metal*	195	D5120	Complete Lower Denture	250
D2781	Crown, ¾ Cast Base Metal*	195	D5130	Immed. Complete Upper Denture	250
			D5140	Immed. Complete Lower Denture	250
			D5211	Upper Part. Denture, Resin Base	375
			D5212	Lower Part. Denture, Resin Base	375

SPECIALTY COPAYMENT SCHEDULE*		Member Copayment	
Endodontic Services			<p>* LIBERTY Dental Plan will arrange for you to receive services from a Contracted Dental Specialist if the necessary treatment is outside the scope of General Dentistry. Your General Dentist will initiate the referral process with LIBERTY Dental Plan. The proper referral process must be utilized for specialty services to be covered under your plan. The Member Copayments listed on the left will apply when services are performed by a LIBERTY Dental Plan Specialist. X-rays for diagnostic purposes are benefits in the General Dentist's office only.</p>
D3310	Root Canal, Anterior	385	
D3320	Root Canal, Bicuspid	470	
D3330	Root Canal, Molar	580	
D3346	Retreat Root Canal, Anterior	385	
D3347	Retreat Root Canal, Bicuspid	470	
D3348	Retreat Root Canal, Molar	580	
D3410	Apicoectomy, Anterior	545	
D3421	Apicoectomy, Bicuspid 1 st Root	565	
D3425	Apicoectomy, Molar 1 st Root	485	
D3426	Apicoectomy, Each Add. Root	485	
D3420	Retrograde Filling, Per Root	170	
Periodontic Services			
D4260	Osseous Surgery, 4+ Teeth per Quad.	675	
D4261	Osseous Surgery, 1-3 Teeth per Quad.	675	
Oral Surgery Services			
D7210	Surgical Extraction, Erupted Tooth	145	
D7220	Extraction, Soft Tissue Impaction	165	
D7230	Extraction, Partial Bony Impaction	220	
D7240	Extraction, Full Bony Impaction	260	
D7241	Extraction, Full Bony, Unusual	290	
D7250	Surgical Extraction, Residual Roots	95	
D7285	Biopsy of Oral Tissue, Hard	195	
D7286	Biopsy of Oral Tissue, Soft	195	
D7310	Alveoloplasty with Ext., Per Quad.	130	
D7311	Alveoloplasty with Ext., 1-3 Teeth	130	
D7320	Alveoloplasty, w/o Ext., Per Quad.	160	
D7321	Alveoloplasty, w/o Ext., 1-3 Teeth	160	
D7471	Removal of Lateral Exostosis	260	

Limitations

1. Prophylaxis are covered once every six consecutive months.
2. Full Mouth X-rays are limited to once every 36 consecutive months.
3. Fluoride Treatments are covered once every 6 consecutive months, up to the 18th birth date.
4. Sealants are covered only on the first and second permanent molars and up to the 14th birth date.
5. Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years, and consistent with professionally recognized standards of dental practice.
6. Replacement of existing Full and Partial Dentures are covered once per arch every 5 years, except when they cannot be made functional through relines or repairs.
7. Denture Relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice.
8. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

Exclusions

1. Any procedure not specifically listed as a Covered Benefit
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit
4. Procedures considered experimental, treatment involving implants or pharmacological regimens (See "Independent Medical Review" on page 5)
5. Oral surgery requiring the setting of bone fractures or bone dislocations
6. Hospitalization
7. Out-patient services
8. Ambulance services
9. Durable Medical Equipment
10. Mental Health services
11. Chemical Dependency services
12. Home Health services
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist
14. Treatment started before the member was eligible, or after the member was no longer eligible
15. Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional(e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones) unless otherwise covered as an orthodontic benefit
16. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice
17. Treatment of malignancies, cysts, or neoplasms
18. Orthodontic treatment started prior to member's effective date of coverage
19. Appliances needed to increase vertical dimension or restore occlusion
20. Any services performed outside of your assigned dental office, unless expressly authorized by Liberty Dental Plan, or unless as outlined and covered in "Emergency Dental Care" section

Orthodontic Exclusions

1. Lost, stolen or broken appliances
2. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition)
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics
4. Myofunctional therapy
5. Treatment of cleft palate
6. Treatment of micrognathia
7. Treatment of macroglossia