NV-500 POS (Ortho-375) Plan

	Tier I	Tier II	Tier III*
Provider Network	LIBERTY Dental Plan EPO	DentalGuard Preferred Select	Any Licensed Dentist
Provider Reimbursement	LIBERTY Dental Plan EPO Contracted Fee less Member Co-payment	PPO Fee Schedule	Regional Usual & Customary*
Diagnostic Services Oral Evaluations (Examinations) Radiographs (X-rays) Pulp Vitality Tests Diagnostic Casts (Study Models)	See Attached NV-500 Co-payment Schedule	Plan Pays 100% Member Pays 0% Deductible Waived	Plan Pays 90% Member Pays 10% Deductible Waived
Preventive Services Prophylaxis (cleaning) Fluoride Treatments Space Maintainers	See Attached NV-500 Co-payment Schedule	Plan Pays 100% Member Pays 0% Deductible Waived	Plan Pays 90% Member Pays 10% Deductible Waived
Basic Services Sealants Fillings Palliative Treatment General Anesthesia Occlusal Guard Denture/Partial Related Services: Adjustments, Rebase, Reline, Repairs Tissue Conditioning	See Attached NV-500 Co-payment Schedule	Plan pays 80% Member pays 20% Deductible Applies	Plan pays 70% Member pays 30% Deductible Applies
Endodontic Services Root Canals & Associated Services	See Attached NV-500 Co-payment Schedule	Plan pays 80% Member pays 20% Deductible Applies	Plan pays 70% Member pays 30% Deductible Applies
Periodontal Services Surgical & Non Surgical Services Associated with Gum Tissue	See Attached NV-500 Co-payment Schedule	Plan pays 80% Member pays 20% Deductible Applies	Plan pays 70% Member pays 30% Deductible Applies
Oral & Maxillofacial Services Extractions & Associated Services	See Attached NV-500 Co-payment Schedule	Plan pays 80% Member pays 20% Deductible Applies	Plan pays 70% Member pays 30% Deductible Applies
Major Services Single Crowns, Inlays, Onlays, Veneers, Bridges Services Related to Crowns, Bridges Dentures, Partial Dentures	See Attached NV-500 Co-payment Schedule	Plan Pays 50% Member Pays 50% Deductible Applies	Plan Pays 40% Member Pays 60% Deductible Applies
Implant Services Surgical Placement & Associated Services	See Attached NV-500 Co-payment Schedule	Not Covered	Not Covered
Orthodontic Services Tier I: Child and Adult Coverage	See Attached Ortho-375 Co-payment Schedule	Not Covered	Not Covered
Calendar Year Deductible **	None	$50 pp/$150 family	$75 pp/$225 family
Calendar Year Maximum **	None	$1,500	$1,000
Orthodontic Lifetime Maximum	None	N/A	N/A

*Tier III (Out of Network) pays lesser of submitted charges or the Regional & Customary Rate as defined by the 80th percentile of MDR (Medical Data Research) fee schedule published by FAIR Health.

** Tier II and Tier III Calendar Year Deductibles and Calendar Year Maximums accumulate together

This is a summary of the benefit plan only. Please refer to the Evidence of Coverage for complete benefit plan information.

LIBERTY Dental Plan of Nevada, Inc.

NV-500 POS (Ortho-375) PLAN SCHEDULE OF BENEFITS

Covered Benefits, Member Co-payments, Limitations & Exclusions

No Annual Deductible
No Annual Dollar Amount Maximum

- ✓ *Provider office pre-assignment is not required. However, members must visit 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 dentally necessary and outside the scope of general dentistry.*
- ✓ *Member Co-payments are payable to the dental office at the time services are rendered.*
- ✓ *This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.*
- ✓ *Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.*

CDT Code	Description	Member Co-payment
	Diagnostic Services	
D0120	Periodic oral evaluation	$0.00
D0140	Limited oral evaluation	$0.00
D0145	Oral evaluation under age 3	$0.00
D0150	Comprehensive oral evaluation	$0.00
D0160	Oral evaluation, problem focused	$0.00
D0170	Re-evaluation, limited, problem focused	$0.00
D0171	Re-evaluation, post operative office visit	$0.00
D0180	Comprehensive periodontal evaluation	$0.00
D0210	Intraoral, complete series of radiographic images	$0.00
D0220	Intraoral, periapical, first radiographic image	$0.00
D0230	Intraoral, periapical, each add 'l radiographic image	$0.00
D0240	Intraoral, occlusal radiographic image	$0.00
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0.00
D0251	Extra-oral posterior dental radiographic image	$0.00
D0270	Bitewing, single radiographic image	$0.00
D0272	Bitewings, two radiographic images	$0.00
D0273	Bitewings, three radiographic images	$0.00
D0274	Bitewings, four radiographic images	$0.00
D0277	Vertical bitewings, 7 to 8 radiographic images	$0.00
D0330	Panoramic radiographic image	$0.00
D0415	Collection of microorganisms for culture	$20.00
D0425	Caries susceptibility tests	$10.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D0472	Accession of tissue, gross exam, prep & report	$16.00
D0473	Accession of tissue, gross/micro. exam, prep, report	$16.00
D0474	Accession of tissue, gross/micro. exam, report	$16.00
	Preventive Services	
D1110	Prophylaxis, adult	$0.00
	Prophylaxis, adult (additional prophylaxis)	$45.00
D1120	Prophylaxis, child	$0.00
	Prophylaxis, child (additional prophylaxis)	$35.00
D1206	Topical application of fluoride varnish	$0.00
D1208	Topical application of fluoride, excluding varnish	$0.00
	up to the 18th birthday (additional fluoride)	$10.00
D1310	Nutritional counseling for control of dental disease	$0.00

CDT Code	Description	Member Co-payment
	Preventive Services (continued)	
D1320	Tobacco counseling, control/prevention oral disease	$0.00
D1330	Oral hygiene instruction	$0.00
D1351	Sealant, per tooth	$6.00
D1352	Preventive resin restoration, permanent tooth	$6.00
D1353	Sealant repair, per tooth	$0.00
D1510	Space maintainer, fixed, unilateral	$20.00
D1515	Space maintainer, fixed, bilateral	$20.00
D1520	Space maintainer, removable, unilateral	$20.00
D1525	Space maintainer, removable, bilateral	$20.00
D1550	Re-cement or re-bond space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00
	Restorative Services	
D2140	Amalgam, one surface, primary or permanent	$0.00
D2150	Amalgam, two surfaces, primary or permanent	$0.00
D2160	Amalgam, three surfaces, primary or permanent	$0.00
D2161	Amalgam, four or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite, one surface, anterior	$7.00
D2331	Resin-based composite, two surfaces, anterior	$15.00
D2332	Resin-based composite, three surfaces, anterior	$21.00
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$28.00
D2390	Resin-based composite crown, anterior	$0.00
D2391	Resin-based composite, one surface, posterior	$50.00
D2392	Resin-based composite, two surfaces, posterior	$54.00
D2393	Resin-based composite, three surfaces, posterior	$60.00
D2394	Resin-based composite, four or more surfaces, posterior	$79.00

***GUIDELINE for Inlays, Onlays, Single Crowns:**

The total maximum amount chargeable to the member for elective upgraded procedures 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 material, if elected member may be charged up to the maximum per tooth charge of $250.00 if codes are not listed as covered benefits.

2. Noble or high noble Metal: are considered elective upgraded material, if elected the member may be charged up to the maximum per tooth charge of $250.00.

D2510	Inlay, metallic, one surface	$120.00
D2520	Inlay, metallic, two surfaces	$136.00
D2530	Inlay, metallic, three or more surfaces	$144.00
D2542	Onlay, metallic, two surfaces	$144.00
D2543	Onlay, metallic, three surfaces	$152.00
D2544	Onlay, metallic, four or more surfaces	$160.00
D2610	Inlay, porcelain/ceramic, one surface	$128.00*
D2620	Inlay, porcelain/ceramic, two surfaces	$136.00*
D2630	Inlay, porcelain/ceramic, three or more surfaces	$144.00*
D2642	Onlay, porcelain/ceramic, two surfaces	$152.00*
D2643	Onlay, porcelain/ceramic, three surfaces	$160.00*
D2644	Onlay, porcelain/ceramic, four or more surfaces	$168.00
D2650	Inlay, resin-based composite, one surface	$120.00
D2651	Inlay, resin-based composite, two surfaces	$128.00
D2652	Inlay, resin-based composite, three or more surfaces	$144.00
D2662	Onlay, resin-based composite, two surfaces	$144.00
D2663	Onlay, resin-based composite, three surfaces	$152.00
D2664	Onlay, resin-based composite, four or more surfaces	$160.00
D2710	Crown, resin-based composite (indirect)	$49.00
D2712	Crown, ¾ resin-based composite (indirect)	$49.00
D2720	Crown, resin with high noble metal	$59.00*

CDT Code	Description	Member Co-payment
	Restorative Services (continued)	
D2721	Crown, resin with predominantly base metal	$59.00
D2722	Crown, resin with noble metal	$59.00*
D2740	Crown, porcelain/ceramic substrate	$95.00*
D2750	Crown, porcelain fused to high noble metal	$115.00*
D2751	Crown, porcelain fused to predominantly base metal	$115.00
D2752	Crown, porcelain fused to noble metal	$115.00*
D2780	Crown, ¾ cast high noble metal	$99.00*
D2781	Crown, ¾ cast predominantly base metal	$99.00
D2782	Crown, ¾ cast noble metal	$99.00*
D2783	Crown, ¾ porcelain/ceramic	$115.00*
D2790	Crown, full cast high noble metal	$99.00*
D2791	Crown, full cast predominantly base metal	$99.00
D2792	Crown, full cast noble metal	$99.00*
D2794	Crown, titanium	$99.00*
D2799	Provisional crown	$64.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$0.00
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$0.00
D2920	Re-cement or re-bond crown	$0.00
D2930	Prefabricated stainless steel crown, primary tooth	$9.00
D2931	Prefabricated stainless steel crown, permanent tooth	$14.00
D2932	Prefabricated resin crown	$9.00
D2933	Prefabricated stainless steel crown with resin window	$10.00
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$10.00
D2940	Protective restoration	$0.00
D2950	Core buildup, including any pins when required	$18.00
D2951	Pin retention, per tooth, in addition to restoration	$8.00
D2952	Post and core in addition to crown, indirectly fabricated	$18.00
D2953	Each additional indirectly fabricated post, same tooth	$8.00
D2954	Prefabricated post and core in addition to crown	$18.00
D2955	Post removal	$12.00
D2957	Each additional prefabricated post, same tooth	$10.00
D2960	Labial veneer (resin laminate), chairside	$200.00
D2961	Labial veneer (resin laminate), laboratory	$325.00
D2962	Labial veneer (porcelain laminate), laboratory	$500.00
D2971	Additional procedure to construct new crown, existing partial denture frame	$24.00
D2980	Crown repair necessitated by restorative material failure	$24.00
	Endodontic Services	
D3110	Pulp cap, direct (excluding final restoration)	$0.00
D3120	Pulp cap, indirect (excluding final restoration)	$0.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$0.00
D3221	Pulpal debridement, primary and permanent teeth	$6.00
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$0.00
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$0.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$15.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$49.00
D3330	Endodontic therapy, molar (excluding final restoration)	$99.00
D3331	Treatment of root canal obstruction; non-surgical access	$175.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	$64.00
D3333	Internal root repair of perforation defects	$88.00
D3346	Retreatment of previous root canal therapy, anterior	$15.00

CDT Code	Description	Member Co-payment
	Endodontic Services (continued)	
D3347	Retreatment of previous root canal therapy, bicuspid	$49.00
D3348	Retreatment of previous root canal therapy, molar	$99.00
D3351	Apexification/recalcification, initial visit	$64.00
D3352	Apexification/recalcification, interim medication replacement	$64.00
D3353	Apexification/recalcification, final visit	$64.00
D3410	Apicoectomy, anterior	$45.00
D3421	Apicoectomy, bicuspid (first root)	$45.00
D3425	Apicoectomy, molar (first root)	$45.00
D3426	Apicoectomy, (each additional root)	$20.00
D3430	Retrograde filling, per root	$15.00
D3450	Root amputation, per root	$15.00
D3910	Surgical procedure for isolation of tooth with rubber dam	$12.00
D3920	Hemisection, not including root canal therapy	$32.00
D3950	Canal preparation and fitting of preformed dowel or post	$0.00
	Periodontal Services	
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$38.00
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$0.00
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$0.00
D4240	Gingival flap procedure, four or more teeth per quadrant	$18.00
D4241	Gingival flap procedure, one to three teeth per quadrant	$18.00
D4245	Apically positioned flap	$88.00
D4249	Clinical crown lengthening, hard tissue	$176.00
D4260	Osseous surgery, four or more teeth per quadrant	$100.00
D4261	Osseous surgery, one to teeth per quadrant	$100.00
D4263	Bone replacement graft, first site in quadrant	$120.00
D4264	Bone replacement graft, each additional site, quadrant	$64.00
D4270	Pedicle soft tissue graft procedure	$216.00
D4273	Autogenous connective tissue graft procedure, first tooth	$0.00
D4274	Distal or proximal wedge procedure	$128.00
D4275	Non-autogenous connective tissue graft, first tooth	$0.00
D4277	Free soft tissue graft, first tooth	$216.00
D4278	Free soft tissue graft, each additional tooth	$216.00
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$0.00
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$0.00
D4320	Provisional splinting, intracoronal	$72.00
D4321	Provisional splinting, extracoronal	$72.00
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	$18.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$18.00
D4355	Full mouth debridement	$18.00
D4381	Localized delivery of antimicrobial agent/per tooth	$18.00
D4910	Periodontal maintenance	$10.00
D4920	Unscheduled dressing change (other than treating dentist or staff)	$5.00
	Removable Prosthodontic Services	
D5110	Complete denture, maxillary	$145.00
D5120	Complete denture, mandibular	$145.00
D5130	Immediate denture, maxillary	$145.00
D5140	Immediate denture, mandibular	$145.00
D5211	Maxillary partial denture, resin base	$115.00
D5212	Mandibular partial denture, resin base	$115.00
D5213	Maxillary partial denture, cast metal, resin base	$170.00
D5214	Mandibular partial denture, cast metal, resin base	$170.00

CDT Code	Description	Member Co-payment
	Removable Prosthodontic Services (continued)	
D5221	Immediate maxillary partial denture, resin base	$115.00
D5222	Immediate mandibular partial denture, resin base	$115.00
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$170.00
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$170.00
D5225	Maxillary partial denture, flexible base	$300.00
D5226	Mandibular partial denture, flexible base	$300.00
D5281	Removable unilateral partial denture, one piece cast metal	$120.00
D5410	Adjust complete denture, maxillary	$0.00
D5411	Adjust complete denture, mandibular	$0.00
D5421	Adjust partial denture, maxillary	$0.00
D5422	Adjust partial denture, mandibular	$0.00
D5510	Repair broken complete denture base	$0.00
D5520	Replace missing or broken teeth, complete denture	$5.00
D5610	Repair resin denture base	$0.00
D5620	Repair cast framework	$0.00
D5630	Repair or replace broken clasp, per tooth	$5.00
D5640	Replace broken teeth, per tooth	$5.00
D5650	Add tooth to existing partial denture	$0.00
D5660	Add clasp to existing partial denture, per tooth	$0.00
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$40.00
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$40.00
D5710	Rebase complete maxillary denture	$0.00
D5711	Rebase complete mandibular denture	$0.00
D5720	Rebase maxillary partial denture	$0.00
D5721	Rebase mandibular partial denture	$0.00
D5730	Reline complete maxillary denture, chairside	$25.00
D5731	Reline complete mandibular denture, chairside	$25.00
D5740	Reline maxillary partial denture, chairside	$25.00
D5741	Reline mandibular partial denture, chairside	$25.00
D5750	Reline complete maxillary denture, laboratory	$25.00
D5751	Reline complete mandibular denture, laboratory	$25.00
D5760	Reline maxillary partial denture, laboratory	$25.00
D5761	Reline mandibular partial denture, laboratory	$25.00
D5810	Interim complete denture, maxillary	$88.00
D5811	Interim complete denture, mandibular	$88.00
D5820	Interim partial denture, maxillary	$18.00
D5821	Interim partial denture, mandibular	$18.00
D5850	Tissue conditioning, maxillary	$0.00
D5851	Tissue conditioning, mandibular	$0.00
	Implant Services	
GUIDELINE: Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.		
D6010	Surgical placement of implant body, endosteal	$2,000.00
D6056	Prefabricated abutment, includes modification and placement	$210.00
D6058	Abutment supported porcelain/ceramic crown	$1,110.00
D6059	Abutment supported porcelain fused to high noble crown	$1,096.00
D6060	Abutment supported porcelain fused to base metal crown	$1,035.00
D6061	Abutment supported porcelain fused to noble metal crown	$1,056.00
D6062	Abutment supported cast metal crown, high noble	$1,003.00
D6063	Abutment supported cast metal crown, base metal	$861.00
D6064	Abutment supported cast metal crown, noble metal	$912.00
D6094	Abutment supported crown, titanium	$670.00

CDT Code	Description	Member Co-payment
	Implant Services (continued)	
D6065	Implant supported porcelain/ceramic crown	$1,040.00
D6066	Implant supported porcelain fused to high noble crown	$1,013.00
D6067	Implant supported metal crown	$984.00
D6068	Abutment supported retainer, porcelain/ceramic FPD	$1,110.00
D6069	Abutment supported retainer, metal FPD, high noble	$1,096.00
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$1,035.00
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$1,056.00
D6072	Abutment supported retainer, cast metal FPD, high noble	$1,028.00
D6073	Abutment supported retainer, cast metal FPD, base metal	$930.00
D6074	Abutment supported retainer, cast metal FPD, noble	$1,005.00
D6194	Abutment supported retainer crown, FPD, titanium	$670.00
D6075	Implant supported retainer for ceramic FPD	$1,092.00
D6076	Implant supported retainer for porcelain fused metal FPD	$1,064.00
D6077	Implant supported retainer for cast metal FPD	$984.00
D6092	Re-cement or re-bond implant/abutment supported crown	$45.00
D6093	Re-cement or re-bond implant/abutment supported FPD	$65.00
	Fixed Prosthodontic Services	
***GUIDELINE for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:** **The total maximum amount chargeable to the member for elective upgraded procedures 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 material, if elected member may be charged up to the maximum per tooth charge of $250.00 if codes are not listed as covered benefits. **2. Noble or high noble Metal:** are considered elective upgraded material, if elected the member may be charged up to the maximum per tooth charge of $250.00.		
D6205	Pontic, indirect resin based composite	$99.00
D6210	Pontic, cast high noble metal	$99.00*
D6211	Pontic, cast predominantly base metal	$99.00
D6212	Pontic, cast noble metal	$99.00*
D6214	Pontic, titanium	$99.00*
D6240	Pontic, porcelain fused to high noble metal	$115.00*
D6241	Pontic, porcelain fused to predominantly base metal	$115.00
D6242	Pontic, porcelain fused to noble metal	$115.00*
D6245	Pontic, porcelain/ceramic	$65.00*
D6250	Pontic, resin with high noble metal	$99.00*
D6251	Pontic, resin with predominantly base metal	$99.00
D6252	Pontic, resin with noble metal	$99.00*
D6253	Provisional pontic	$99.00
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$80.00
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	$80.00*
D6549	Resin retainer, for resin bonded fixed prosthesis	$80.00
D6600	Retainer inlay, porcelain/ceramic, two surfaces	$136.00*
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	$144.00*
D6602	Retainer inlay, cast high noble metal, two surfaces	$136.00*
D6603	Retainer inlay, cast high noble metal, three or more surfaces	$144.00*
D6604	Retainer inlay, cast base metal, two surfaces	$136.00
D6605	Retainer inlay, cast base metal, three or more surfaces	$144.00
D6606	Retainer inlay, cast noble metal, two surfaces	$128.00*
D6607	Retainer inlay, cast noble metal, three or more surfaces	$144.00*
D6624	Retainer inlay, titanium	$144.00*

CDT Code	Description	Member Co-payment
	Fixed Prosthodontic Services (continued)	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$152.00*
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$160.00*
D6610	Retainer onlay, cast high noble metal, two surfaces	$144.00*
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$152.00*
D6612	Retainer onlay, cast base metal, two surfaces	$144.00
D6613	Retainer onlay, cast base metal, three or more surfaces	$152.00
D6614	Retainer onlay, cast noble metal, two surfaces	$144.00*
D6615	Retainer onlay, cast noble metal three or more surfaces	$152.00*
D6634	Retainer onlay, titanium	$152.00*
D6710	Retainer crown, indirect resin based composite	$55.00
D6720	Retainer crown, resin with high noble metal	$55.00*
D6721	Retainer crown, resin with predominantly base metal	$55.00
D6722	Retainer crown, resin with noble metal	$55.00*
D6740	Retainer crown, porcelain/ceramic	$55.00*
D6750	Retainer crown, porcelain fused to high noble metal	$185.00*
D6751	Retainer crown, porcelain fused to predominantly base metal	$185.00
D6752	Retainer crown, porcelain fused to noble metal	$185.00*
D6780	Retainer crown, ¾ cast high noble metal	$185.00*
D6781	Retainer crown, ¾ cast predominantly base metal	$185.00
D6782	Retainer crown, ¾ cast noble metal	$185.00*
D6783	Retainer crown, ¾ porcelain/ceramic	$185.00*
D6790	Retainer crown, full cast high noble metal	$99.00*
D6791	Retainer crown, full cast predominantly base metal	$99.00
D6792	Retainer crown, full cast noble metal	$99.00*
D6793	Provisional retainer crown	$65.00
D6794	Retainer crown, titanium	$99.00*
D6930	Re-cement or re-bond fixed partial denture	$0.00
D6940	Stress breaker	$10.00
D6980	Fixed partial denture repair, restorative material failure	$24.00
	Oral & Maxillofacial Services	
D7111	Extraction, coronal remnants, deciduous tooth	$0.00
D7140	Extraction, erupted tooth or exposed root	$0.00
D7210	Surgical removal of erupted tooth	$12.00
D7220	Removal of impacted tooth, soft tissue	$18.00
D7230	Removal of impacted tooth, partially bony	$28.00
D7240	Removal of impacted tooth, completely bony	$45.00
D7241	Removal impacted tooth, complete bony, complication	$45.00
D7250	Surgical removal residual tooth roots, cutting procedure	$0.00
D7261	Primary closure of a sinus perforation	$152.00
D7270	Tooth reimplantation and/or stabilization, accident	$144.00
D7280	Surgical access of an unerupted tooth	$72.00
D7282	Mobilization of erupted/malpositioned tooth	$48.00
D7283	Placement, device to facilitate eruption, impaction	$48.00
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$0.00
D7286	Incisional biopsy of oral tissue, soft	$0.00
D7287	Exfoliative cytological sample collection	$5.00
D7288	Brush biopsy, transepithelial sample collection	$5.00
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$45.00
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$40.00
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$45.00
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$40.00
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$64.00
D7350	Vestibuloplasty, ridge extension	$88.00

CDT Code	Description	Member Co-payment
	Oral & Maxillofacial Services (continued)	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$72.00
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$144.00
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$80.00
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$112.00
D7471	Removal of lateral exostosis, maxilla or mandible	$88.00
D7472	Removal of torus palatinus	$64.00
D7473	Removal of torus mandibularis	$64.00
D7485	Surgical reduction of osseous tuberosity	$40.00
D7510	Incision & drainage of abscess, intraoral soft tissue	$10.00
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$12.00
D7520	Incision & drainage of abscess, extraoral soft tissue	$10.00
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$12.00
D7530	Remove foreign body, mucosa, skin, tissue	$12.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$40.00
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$0.00
D7963	Frenuloplasty	$0.00
D7970	Excision of hyperplastic tissue, per arch	$20.00
D7971	Excision of pericoronal gingiva	$32.00
	Adjunctive General Services	
D9110	Palliative (emergency) treatment, minor procedure	$0.00
D9120	Fixed partial denture sectioning	$0.00
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$0.00
D9211	Regional block anesthesia	$0.00
D9212	Trigeminal division block anesthesia	$0.00
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0.00
GUIDELINE: Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.		
D9219	Evaluation for deep sedation or general anesthesia	$0.00
D9223	Deep sedation/general anesthesia, each 15 minute increment	$125.00**
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$35.00
D9243	Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	$125.00**
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$100.00
D9310	Consultation, other than requesting dentist	$0.00
D9430	Office visit, observation, regular hours, no other services	$0.00
D9440	Office visit, after regularly scheduled hours	$20.00
D9450	Case presentation, detailed & extensive treatment	$0.00
D9630	Other drugs and/or medicaments, by report	$13.00
D9910	Application of desensitizing medicament	$0.00
D9911	Application of desensitizing resin for cervical, root surface, per tooth	$0.00
D9930	Treatment of complications, post surgical, unusual, by report	$5.00
D9940	Occlusal guard, by report	$160.00
D9942	Repair and/or reline of occlusal guard	$40.00
D9950	Occlusion analysis, mounted case	$0.00
D9951	Occlusal adjustment, limited	$13.00
D9952	Occlusal adjustment, complete	$16.00
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	$5.00
D9986	Missed appointment	$0.00
D9987	Cancelled appointment	$0.00
	Office visit, per visit	$0.00

LIBERTY Dental Plan of Nevada, Inc.

Ortho-375 PLAN SCHEDULE OF BENEFITS

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	$200.00
D0470	Diagnostic casts	$150.00
D9310	Consultation, other than requesting dentist	$0.00
D8010	Limited orthodontic treatment of the primary dentition	$2,050.00
D8020	Limited orthodontic treatment of the transitional dentition	$2,050.00
D8030	Limited orthodontic treatment of the adolescent dentition	$2,050.00
D8040	Limited orthodontic treatment of the adult dentition	$2,050.00
D8050	Interceptive orthodontic treatment of the primary dentition	$925.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$925.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,100.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,100.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,250.00
D8210	Removable appliance therapy	$400.00
D8220	Fixed appliance therapy	$400.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$450.00
D9986	Missed appointment	$25.00
D9987	Cancelled appointment	$0.00

Orthodontic Exclusions:

1. Replacement of lost or stolen orthodontic appliances
2. Lost, stolen or broken appliances
3. Orthodontic treatment started prior to member's effective date of coverage unless covered through an orthodontic takeover provision.
4. 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).
5. Treatment in progress at the time of eligibility, unless included as an orthodontic rider to the groups benefits.
6. Temporomandibular joint syndrome (TMJ) surgical orthodontics
7. Myofunctional therapy
8. Treatment of cleft palate
9. Treatment of micrognathia
10. Treatment of macroglossia
11. Changes in orthodontic treatment necessitated by accident of any kind.
12. Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits.
13. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient at a fee not to exceed $130 per month.
14. In the event of termination the patient is responsible for the usual fee of the treating dentist pro-rated over the remainder of treatment and/or retention.

Tier 1 Limitations:

1. Prophylaxis procedures are covered once every 6 consecutive months.
2. Complete series of x-rays (full mouth x-rays) or panoramic films are covered once every 36 consecutive months.
3. Fluoride treatments are covered once every 6 consecutive months.
4. Sealants are covered only on the first and second permanent molars with no caries (decay) for dependent children up to the 14th birth date. Limited to once per tooth per 36 month period.
5. Scaling and root planing per quadrant/site is covered once every 24 consecutive months.
6. Replacement of crowns, labial veneers or fixed partial dentures (bridgework), per unit, are limited to once every 5 year period.
7. Replacement of an existing full and partial denture is covered once per arch every 5 years if the appliance cannot be made functional through reline or repair.
8. Denture relines are covered twice every 12 consecutive months.
9. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to members age 16 and over.
10. The replacement of an amalgam or resin restoration in less than twelve months by the same contracted dentist or office is not chargeable to the Plan or the member.
11. Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dentist consultant are not covered.
12. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for 2 non-responsive sites in a quadrant with 5mm pockets or deeper plus inflammation.
13. For treatment plans involving 7 or more units of crowns and/or fixed partial dentures (bridges), contracted providers may charge an additional $200 co-payment per unit. In such cases, the first 6 units, as described in limitation #6 above, are covered at the specified member co-payment amount only, as documented in this Schedule of Benefits.
14. Fixed partial dentures (bridges) are covered when: replacing a “like-for-like” existing fixed partial denture with identical pontics and abutment teeth with good prognosis; abutment teeth qualify for crowns on their own merit, as described in limitation #6 above; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch.
15. Surgical periodontal services are limited to once every 36 month period.
16. Full mouth debridement is limited to once in a 24 month period.
17. Pediatric referrals, if authorized by LIBERTY, are covered only for dependent children through the age of 6 unless the child qualifies under the American with Disabilities Act (ADA).

Tier 1 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. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), 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.
6. 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.
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
9. 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.
10. The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
11. Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
12. 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.
13. Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
14. Consultations for non-covered services.

Tier 2 & 3 Limitations:

1. Benefits in excess of the yearly or lifetime maximum benefits. Please see the Benefit Plan Summary for Calendar Year maximum benefits and lifetime maximum benefit limitations on certain services.
2. Prophylaxis or periodontal maintenance procedures are covered twice every 12 consecutive months.
3. Complete series of x-rays (full mouth x-rays) or panoramic images are covered once every 36 consecutive months.
4. Fluoride treatments are covered once every 6 consecutive months.
5. Sealants are covered only on the first and second permanent molars with no caries (decay) for dependent children up to the 14th birth date. Limited to once per tooth per 36 month period.
6. Scaling and root planing per quadrant/site is covered once every 24 consecutive months.
7. Replacement of crowns, labial veneers or fixed partial dentures (bridgework), per unit, are limited to once every 5 year period.
8. Replacement of an existing full and partial denture is covered once per arch every 5 years if the appliance cannot be made functional through reline or repair.
9. Denture relines are covered twice every 12 consecutive months.
10. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to members age 16 and over.
11. The replacement of an amalgam or resin restoration in less than twelve months by the same contracted dentist or office is not chargeable to the Plan or the member.
12. Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dentist consultant are not covered.
13. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for 2 non-responsive sites in a quadrant with 5mm pockets or deeper plus inflammation.
14. Fixed partial dentures (bridges) are covered when: replacing a “like-for-like” existing fixed partial denture with identical pontics and abutment teeth with good prognosis; abutment teeth qualify for crowns on their own merit, as described in limitation #7 above; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch.
15. Surgical periodontal services are limited to once every 36 month period.
16. Full mouth debridement is limited to once every 24 month period.
17. Oral evaluation is limited to 2 every 12 month period.
18. Oral hygiene instruction is limited to once every 24 month period.
19. Bitewing x-rays are limited to not more than 1 series every 6 month period.
20. Charges for adjustment of a prosthesis is limited to 1 per arch every 6 month period.

Tier 2 & 3 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. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), 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.
6. 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.
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
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. 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.
11. Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
12. Consultations for non-covered services.
13. Implants or any prosthesis attached to or dependent upon an implant unless otherwise listed as a covered benefit on the Benefit Plan Summary.
14. Orthodontic services unless otherwise listed as a covered benefit on the Benefit Plan Summary.