

**SUMMARY OF BENEFITS AND  
COPAYMENTS**

These procedures are performed as needed and deemed necessary by your Provider Dentist subject to the Limitation, Exclusions and Governing Administrative Policies of the program.

Enrollee pays

**DIAGNOSTIC**

Oral examination..... No Cost  
 Bitewing radiograph(s) ..... No Cost  
 Panoramic film..... No Cost  
 Pulp vitality tests..... No Cost

**PREVENTIVE**

Prophylaxis (adult/child)-1 per 6 mo/2 per year  
 ..... No Cost  
 Topical application of fluoride including, excluding  
 prophylaxis ..... No Cost

**RESTORATIVE**

Amalgam – one to four surfaces.....No Cost  
 Resin - one to four surfaces, anterior..... No Cost  
 Resin—one - three surfaces, posterior, prim \$45-\$60  
 Resin – four or more posterior, permanent...\$75.00

**ORAL SURGERY**

Routine extraction - single tooth,..... No cost  
 Surgical removal of erupted tooth..... \$15.00  
 Removal of impacted tooth - soft tissue..... \$45.00  
 Removal of impacted tooth - completely bony  
 ..... \$80.00

**PERIODONTICS**

Periodontal scaling & root planning.....\$20.00  
 4+teeth/quadrant. No more than 2 quadrants of  
 periodontal scaling and root planing per  
 appointment/day allowed.

**IMPLANTS**

Please see outline of coverage for the guidelines of  
 implant services. Pages 5-6.

**PROSTHETICS**

Crown -.....\$70-\$100 +  
 LAB fees (**please see guidelines in coverage  
 outline.**)  
 Denture - complete upper or lower ..... \$120.00  
 Denture - upper or lower partial w/resin base  
 (including any conventional clasps,  
 rests & teeth)..... \$110.00  
 Denture repair..... \$5.00  
 Partial denture repair..... (see coverage outline)  
 Denture reline/rebase chairside  
 (complete or partial)...(see coverage outline)  
 Bridge pontic..... \$280.00  
*(Lab fees may be required in addition to co-pay for  
 crown and bridge work)*

**ENDODONTICS**

Root canal therapy – anterior..... \$40.00  
 Root canal therapy – bicuspid..... \$80.00  
 Root canal therapy – molar..... \$100.00  
 (excluding final restoration cost)

**ADJUNCTIVE GENERAL SERVICES**

Local anesthesia..... No Cost  
 Analgesia (nitrous-oxide per 15 minutes)..... \$15.00

**ORTHODONTICS**

Children and adults treatment – Up to 24 months  
 Consultation.....No Cost  
 Orthodontic Treatment.....\$1,300  
**PLEASE SEE EVIDENCE OF COVERAGE FOR  
 COMPLETE EXPLANATION OF ORTHODONTIC  
 FEES AND SERVICES.**

**Please note:** This is only a summary of the co-payments and  
 benefits. For more information, please call:

**1 (800) 578-2082**

An Outline of Coverage will be sent to you upon request or Email:  
 info@pbainsurance.net

**LIBERTY DENTAL  
 CALIFORNIA LS100**

*Presented by*

**PROFESSIONAL BENEFIT  
 ADMINISTRATORS**



**1-800-578-2082**

**www.pbainsurance.net**



## HOW IT WORKS

When you enroll, select a Participating Dentist from the list. This location is now the center for all of your dental needs.

After you have enrolled, you can obtain an Outline of Coverage that fully describes the benefits of your dental plan as well as a membership card. This card will have the address and telephone number of your participating panel dentist. To receive all necessary dental care covered by the plan, simply call your selected provider to make an appointment.

Remember to always contact your selected panel dentist. Dental services which are not performed by your panel provider nor prior authorized will not be covered by the program.

## WHO CAN JOIN

You can also enroll your eligible dependents, which include your lawful spouse and unmarried children; including step-children, legally adopted and foster children to the limiting age as specified by state law.

### Liberty Dental HMO

#### **Bi-Weekly Payroll Deductions**

Individual.....	\$24.00
Individual & one dependent.....	\$32.00
Family.....	\$41.00

#### **Monthly Bank Draft Deductions**

Individual.....	\$49.83
Employee & one dependent.....	\$62.83
Family.....	\$88.83

## No Charge Services

- X-Rays
- Routine Cleanings
- Topical Fluoride
- Oral Exams
- Local Anesthesia
- All other dental procedures are covered at a substantial savings to you

## No Claim Forms

- The dentist is prepaid directly.
- Most routine and preventive care is covered.

## No Deductible

## No Annual Dollar Amount Maximum

## Large, Established Dental Network

- You choose your family general dentist from the provider list.
- Each dentist is licensed and is a skilled, experienced professional.

## No Limit To A Specific Number Of Dental Visits Per Year

## Easy To Change From One Participating Dentist To Another

- All it takes is a phone call to Professional Benefit Administrators at (800) 578-2082.

## Specialist Care Available

- Should you need a specialist, your assigned 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.

## No Surprises

- Check with benefits schedule to know in advance what your co-payment will be for each service rendered.
- Co-payments are made directly to the dentist.
- 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.

***Ask about other  
benefits available  
to you***

Short Term Disability  
Long Term Disability  
Vision Plan  
Cancer Plan  
Accident Plan  
FEGLI Alternative  
*FEGLI may quit before you do...*

## No Annual Deductible

## No Annual Dollar Amount Maximum

- Members must select, and be assigned to, a LIBERTY Dental Plan contracted LS100 dental office to utilize covered benefits. Your assigned 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.
- For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.

## Summary of services

ADA Code	Procedure	Member pays
<b>Diagnostic services</b>		
D0120	Periodic oral evaluation	no charge
D0140	Limited oral evaluation	no charge
D0145	Oral Evaluation under age 3	no charge
D0150	Comprehensive oral evaluation	no charge
D0160	Oral evaluation, problem focused	no charge
D0170	Re-evaluation, limited, problem focused	no charge
D0180	Comprehensive periodontal evaluation	no charge
D0210	Intraoral, complete series (includes bitewings)	no charge
D0220	Intraoral, periapical, first film	no charge
D0230	Intraoral, periapical, each additional film	no charge
D0240	Intraoral, occlusal film	no charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	no charge
D0270	Bitewing, single film	no charge
D0272	Bitewings, 2 films	no charge
D0273	Bitewings, 3 films	no charge
D0274	Bitewings, 4 films	no charge
D0277	Vertical bitewings, 7 to 8 films	no charge
D0330	Panoramic Film	no charge
D0415	Collection of microorganisms for culture	no charge
D0425	Caries susceptibility tests	no charge
D0460	Pulp vitality tests	no charge
D0470	Diagnostic casts	no charge
D0472	Accession of tissue, gross exam, prep & report	no charge
D0474	Accession of tissue, gross/micro. exam, report	no charge
<b>Preventive services</b>		
D1110	Prophylaxis, adult	no charge
	Prophylaxis, adult (3rd or more per 12 months)	\$ 45.00
D1120	Prophylaxis, child	no charge
	Prophylaxis, child (3rd or more per 12 months)	\$ 35.00
D1203	Topical application of fluoride, child	no charge
	Topical application fluoride, child (3rd + in 12 mo.)	\$ 10.00
D1204	Topical application of fluoride, adult	no charge
D1206	Topical fluoride varnish	no charge
D1310	Nutritional counseling for control of dental disease	no charge
D1320	Tobacco counseling, control/prevention oral disease	no charge
D1330	Oral hygiene instruction	no charge
D1351	Sealant, per tooth	\$ 5.00



# LS100 Plan

ADA Code	Procedure	Member pays
<b>Preventive services (continued)</b>		
D1352	Preventive resin restoration – permanent tooth	\$ 5.00
D1510	Space maintainer, fixed, unilateral	\$ 15.00
D1515	Space maintainer, fixed, bilateral	\$ 15.00
D1520	Space maintainer, removable, unilateral	\$ 15.00
D1525	Space maintainer, removable, bilateral	\$ 15.00
D1550	Recementation of space maintainer	\$ 5.00
D1555	Removal of fixed space maintainer	\$ 5.00
<b>Restorative</b>		
D2140	Amalgam, 1 surface, primary or permanent	no charge
D2150	Amalgam, 2 surfaces, primary or permanent	no charge
D2160	Amalgam, 3 surfaces, primary or permanent	no charge
D2161	Amalgam, 4 or more surfaces, primary/permanent	no charge
D2330	Resin-based composite, 1 surface, anterior	no charge
D2331	Resin-based composite, 2 surfaces, anterior	no charge
D2332	Resin-based composite, 3 surfaces, anterior	no charge
D2335	Resin-based composite, 4+ surfaces/incisal angle	no charge
D2390	Resin-based composite crown, anterior	\$ 20.00
D2391	Resin-based composite, 1 surface, posterior	\$ 45.00
D2392	Resin-based composite, 2 surfaces, posterior	\$ 50.00
D2393	Resin-based composite, 3 surfaces, posterior	\$ 60.00
D2394	Resin-based composite, 4+ surfaces, posterior	\$ 75.00

## \*GUIDELINES for Inlays, Onlays, and Single Crowns:

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

- Brand name restorations** (e.g. Sunrise, Captek, Vitadur-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.
- Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.
- Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain/ceramic crowns are not covered benefits on molar teeth. Any resin to metal or porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.
- Base metal is the benefit.** If elected, the member may be charged additional lab costs for a) noble metal, b) high noble metal, or c) titanium.

D2510	Inlay, metallic, 1 surface	\$ 80.00*
D2520	Inlay, metallic, 2 surfaces	\$ 85.00*
D2530	Inlay, metallic, 3 or more surfaces	\$ 90.00*
D2542	Onlay, metallic, 2 surfaces	\$ 90.00*
D2543	Onlay, metallic, 3 surfaces	\$ 95.00*
D2544	Onlay, metallic, 4 or more surfaces	\$ 100.00*
D2610	Inlay, porcelain/ceramic, 1 surface	\$ 80.00*
D2620	Inlay, porcelain/ceramic, 2 surfaces	\$ 85.00*
D2630	Inlay, porcelain/ceramic, 3 or more surfaces	\$ 90.00*
D2642	Onlay, porcelain/ceramic, 2 surfaces	\$ 95.00*
D2643	Onlay, porcelain/ceramic, 3 surfaces	\$ 100.00*
D2644	Onlay, porcelain/ceramic, 4 or more surfaces	\$ 110.00*
D2650	Inlay, resin-based composite, 1 surface	\$ 80.00*
D2651	Inlay, resin-based composite, 2 surfaces	\$ 85.00*
D2652	Inlay, resin-based composite, 3 or more surfaces	\$ 90.00*
D2662	Onlay, resin-based composite, 2 surfaces	\$ 90.00*
D2663	Onlay, resin-based composite, 3 surfaces	\$ 95.00*
D2664	Onlay, resin-based composite, 4 or more surfaces	\$ 100.00*
D2710	Crown, resin-based composite (indirect)	\$ 60.00*
D2712	Crown, 3/4 resin-based composite (indirect)	\$ 60.00*
D2720	Crown, resin with high noble metal	\$ 70.00*
D2721	Crown, resin with predominantly base metal	\$ 70.00*
D2722	Crown, resin with noble metal	\$ 70.00*

CDT-2013/2014: Current Dental Terminology, © 2016 American Dental Association. All rights reserved.

# LS100 Plan

ADA Code	Procedure	Member pays
<b>Restorative (continued)</b>		
D2740	Crown, porcelain/ceramic substrate	\$ 70.00*
D2750	Crown, porcelain fused to high noble metal	\$ 70.00*
D2751	Crown, porcelain fused to predominantly base metal	\$ 70.00*
D2752	Crown, porcelain fused to noble metal	\$ 70.00*
D2780	Crown, 3/4 cast high noble metal	\$ 70.00*
D2781	Crown, 3/4 cast predominantly base metal	\$ 70.00
D2782	Crown, 3/4 cast noble metal	\$ 70.00*
D2783	Crown, 3/4 porcelain/ceramic	\$ 70.00*
D2790	Crown, full cast high noble metal	\$ 70.00*
D2791	Crown, full cast predominantly base metal	\$ 70.00
D2792	Crown, full cast noble metal	\$ 70.00*
D2794	Crown, titanium	\$ 70.00*
D2799	Provisional crown	\$ 40.00
D2910	Recement inlay, onlay, partial coverage restoration	no charge
D2915	Recement cast or prefabricated post & core	no charge
D2920	Recement crown	no charge
D2930	Prefabricated stainless steel crown, primary tooth	no charge
D2931	Prefabricated stainless steel crown, permanent tooth	\$ 15.00
D2932	Prefabricated resin crown	\$ 10.00
D2933	Prefabricated stainless steel crown, resin window	\$ 5.00
D2934	Prefabricated esthetic coated SS crown, primary	\$ 5.00
D2940	Protective restoration (temporary)	no charge
D2950	Core build-up, including any pins	\$ 10.00
D2951	Pin retention, per tooth, in addition to restoration	\$ 10.00
D2952	Post & core in addition to crown, indirect fabric.	\$ 20.00*
D2953	Each additional indirect fabric. post, same tooth	\$ 20.00*
D2954	Prefabricated post & core in addition to crown	\$ 20.00
D2955	Post removal (not in conj. with endodontic therapy)	\$ 10.00
D2957	Each additional prefabricated post, same tooth	\$ 10.00
D2960	Labial veneer (resin laminate), chairside	\$ 200.00
D2961	Labial veneer (resin laminate), laboratory	\$ 300.00
D2962	Labial veneer (porcelain laminate), laboratory	\$ 350.00
D2971	Add'l procedure/new crown, existing partial denture	\$ 20.00
D2980	Crown repair, by report	\$ 15.00
<b>Endodontics</b>		
D3110	Pulp cap – direct (excluding final restoration)	no charge
D3120	Pulp cap – indirect (excluding final restoration)	no charge
D3220	Therapeutic pulpotomy (excluding final restoration)	no charge
D3221	Pulpal debridement, primary & permanent teeth	\$ 10.00
D3230	Pulpal therapy (resorbable filling), anterior, primary	\$ 5.00
D3240	Pulpal therapy (resorbable filling), posterior, primary	\$ 10.00
D3310	Anterior (excluding final restoration)	\$ 40.00
D3320	Bicuspid (excluding final restoration)	\$ 80.00
D3330	Molar (excluding final restoration)	\$ 100.00
D3331	Treatment of root canal obstruction; non-surgical	\$ 50.00
D3332	Incomplete endodontic therapy, inoperable	\$ 45.00
D3333	Internal root repair of perforation defects	\$ 55.00
D3346	Retreatment of previous root canal – anterior	\$ 50.00
D3347	Retreatment of previous root canal – bicuspid	\$ 90.00
D3348	Retreatment of previous root canal – molar	\$ 150.00
D3351	Apexification/recalcification/pulp reg. – initial visit	\$ 65.00
D3352	Apexification/recalcification/pulp reg. – interim med.	\$ 55.00
D3353	Apexification/recalcification – final visit	\$ 50.00
D3410	Apicoectomy/periradicular surgery – anterior	\$ 50.00
D3421	Apicoectomy/periradicular surgery – bicuspid	\$ 50.00
D3425	Apicoectomy/periradicular surgery – molar	\$ 50.00
D3426	Apicoectomy/periradicular surgery – ea. add. root	\$ 20.00
D3430	Retrograde filling – per root	\$ 15.00

CDT-2013/2014: Current Dental Terminology, © 2016 American Dental Association. All rights reserved.

# LS100 Plan

ADA Code	Procedure	Member pays
<b>Endodontics (continued)</b>		
D3450	Root Amputation – per root	\$ 50.00
D3910	Surgical procedure for isolation with rubber dam	\$ 20.00
D3920	Hemisection (incl. root removal), not incl. root canal	\$ 90.00
D3950	Canal prep. & fitting of preformed dowel/post	no charge
<b>Periodontics</b>		
D4210	Gingivectomy/gingivoplasty, 4+ teeth per quadrant	\$ 40.00
D4211	Gingivectomy/gingivoplasty, 1-3 teeth per quadrant	\$ 16.00
D4240	Ging. flap procedure, 4+ teeth per quadrant	\$ 85.00
D4241	Ging. flap procedure, 1-3 teeth per quadrant	\$ 85.00
D4245	Apically positioned flap	\$ 96.00
D4249	Clinical crown lengthening, hard tissue	\$ 130.00
D4260	Osseous surgery, 4+ teeth per quadrant	\$ 200.00
D4261	Osseous surgery, 1-3 teeth per quadrant	\$ 100.00
D4263	Bone replacement graft, 1st site in quadrant	\$ 75.00
D4264	Bone replacement graft, ea. additional site, quad.	\$ 40.00
D4265	Biologic materials to aid soft osseous tissue	\$ 95.00
D4266	Guided tissue regeneration - resorbable, per site	\$ 230.00
D4267	Guided tissue regeneration - non resorbable, per site	\$ 275.00
D4270	Pedicle soft tissue graft procedure	\$ 135.00
D4271	Free soft tissue graft procedure (incl. donor site)	\$ 135.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$ 350.00
D4274	Distal/proximal wedge procedure	\$ 90.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$ 380.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$ 350.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$ 380.00
D4320	Provisional splinting - intracoronal	\$ 45.00
D4321	Provisional splinting - extracoronal	\$ 45.00

## GUIDELINE:

No more than two (2) quadrants of periodontal scaling and root planing per appointment/per day are allowable.

D4341	Periodontal scaling & root planing, 4+ teeth/quad.	\$ 20.00
D4342	Periodontal scaling & root planing, 1-3 teeth/quad.	\$ 10.00
D4355	Full mouth debridement	\$ 20.00
D4381	Localized delivery of antimicrobial agent/per tooth	\$ 15.00
D4910	Periodontal maintenance	\$ 35.00
D4920	Unscheduled dressing change/non-treating dentist	no charge

## Prosthodontics – removable

D5110	Complete denture, maxillary	\$ 120.00
D5120	Complete denture, mandibular	\$ 120.00
D5130	Immediate denture, maxillary	\$ 120.00
D5140	Immediate denture, mandibular	\$ 120.00
D5211	Maxillary partial denture, resin base	\$ 110.00
D5212	Mandibular partial denture, resin base	\$ 110.00
D5213	Maxillary partial denture, cast metal/resin base	\$ 150.00
D5214	Mandibular partial denture, cast metal/resin base	\$ 150.00
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$ 120.00
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$ 120.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$ 120.00

ADA Code	Procedure	Member pays
<b>Prosthodontics – removable (continued)</b>		
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$ 120.00
D5225	Maxillary partial denture, flexible base	\$ 150.00
D5226	Mandibular partial denture, flexible base	\$ 150.00
D5281	Removable unilateral partial denture, 1 pc. cast	\$ 105.00
D5410	Adjust complete denture, maxillary	no charge
D5411	Adjust complete denture, mandibular	no charge
D5421	Adjust partial denture, maxillary	no charge
D5422	Adjust partial denture, mandibular	no charge
D5510	Repair broken complete denture base	no charge
D5520	Replace missing/broken teeth, complete denture	\$ 5.00
D5610	Repair resin denture base	no charge
D5620	Repair cast framework	no charge
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	\$ 5.00
D5660	Add clasp to existing partial denture - per tooth	\$ 5.00
D5670	Replace all teeth & acrylic/cast metal frame, max.	\$ 88.00
D5671	Replace all teeth & acrylic/cast metal frame, mand.	\$ 88.00
D5710	Rebase complete maxillary denture	\$ 35.00
D5711	Rebase complete mandibular denture	\$ 35.00
D5720	Rebase maxillary partial denture	\$ 35.00
D5721	Rebase mandibular partial denture	\$ 35.00
D5730	Reline complete maxillary denture, chairside	no charge
D5731	Reline complete mandibular denture, chairside	no charge
D5740	Reline maxillary partial denture, chairside	no charge
D5741	Reline mandibular partial denture, chairside	no charge
D5750	Reline complete maxillary denture, laboratory	\$ 30.00
D5751	Reline complete mandibular denture, laboratory	\$ 30.00
D5760	Reline maxillary partial denture, laboratory	\$ 30.00
D5761	Reline mandibular partial denture, laboratory	\$ 30.00
D5810	Interim complete denture, maxillary	\$ 88.00
D5811	Interim complete denture, mandibular	\$ 88.00
D5820	Interim partial denture, maxillary	\$ 20.00
D5821	Interim partial denture, mandibular	\$ 20.00
D5850	Tissue conditioning, maxillary	no charge
D5851	Tissue conditioning, mandibular	no charge

**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 placement	\$ 210.00
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00
D6059	Abutment supported porcelain/high noble crown	\$1,096.00
D6060	Abutment supported porcelain/base metal crown	\$1,035.00
D6061	Abutment supported porcelain/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
D6065	Implant supported porcelain/ceramic crown	\$1,040.00
D6066	Implant supported porcelain/metal 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	Abut. support. retainer, porc./metal FPD, base metal	\$1,035.00

# LS100 Plan

ADA Code	Procedure	Member pays
<b>Implant services (continued)</b>		
D6071	Abut. support. retainer, porc./metal FPD, noble	\$1,056.00
D6072	Abut. support. retainer, cast metal FPD, high noble	\$1,028.00
D6073	Abut. support. retainer, cast metal FPD, base metal	\$ 930.00
D6074	Abut. support. retainer, cast metal FPD, noble	\$1,005.00
D6194	Abut. supported retainer crown, FPD, titanium	\$ 670.00
D6075	Implant supported retainer for ceramic FPD	\$1,092.00
D6076	Implant supported retainer for porc./metal FPD	\$1,064.00
D6077	Implant supported retainer for cast metal FPD	\$ 984.00
D6092	Recement implant/abutment supported crown	\$ 45.00
D6093	Recement implant/abutment supported FPD	\$ 65.00

## Prosthodontics - fixed

### \* GUIDELINES for Pontics and Abutment Inlays, Onlays and Crowns

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

- Brand name restorations** (e.g. Sunrise, Captek, Vitadur-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.
- Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.
- Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain/ceramic crowns are not covered benefits on molar teeth. Any resin to metal or porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.
- Base metal is the benefit.** If elected, the member may be charged additional lab costs for a) noble metal, b) high noble metal, or c) titanium.

D6205	Pontic, indirect resin based composite	\$ 60.00*
D6210	Pontic, cast high noble metal	\$ 70.00*
D6211	Pontic, cast predominantly base metal	\$ 70.00
D6212	Pontic, cast noble metal	\$ 70.00*
D6214	Pontic, titanium	\$ 70.00*
D6240	Pontic, porcelain fused to high noble metal	\$ 70.00*
D6241	Pontic, porcelain fused to predominantly base metal	\$ 70.00*
D6242	Pontic, porcelain fused to noble metal	\$ 70.00*
D6245	Pontic, porcelain/ceramic	\$ 70.00*
D6250	Pontic, resin with high noble metal	\$ 70.00*
D6251	Pontic, resin with predominantly base metal	\$ 70.00*
D6252	Pontic, resin with noble metal	\$ 70.00*
D6253	Provisional pontic	\$ 70.00
D6545	Retainer, cast metal for resin bonded fixed prosth.	\$ 70.00*
D6548	Retainer, proc./ceramic, resin bonded fixed prosth.	\$ 50.00
D6600	Retainer inlay, porcelain/ceramic, 2 surfaces	\$ 90.00*
D6601	Retainer inlay, porcelain/ceramic, 3 or more surfaces	\$ 100.00*
D6602	Retainer inlay, cast high noble metal, 2 surfaces	\$ 85.00*
D6603	Retainer inlay, cast high noble metal, 3 or more surfaces	\$ 90.00*
D6604	Retainer inlay, cast base metal, 2 surfaces	\$ 85.00
D6605	Retainer inlay, cast base metal, 3 or more surfaces	\$ 85.00
D6606	Retainer inlay, cast noble metal, 2 surfaces	\$ 60.00*
D6607	Inlay, cast noble metal, 3 or more surfaces	\$ 85.00*
D6624	Retainer inlay, Titanium	\$ 95.00
D6608	Retainer onlay, porcelain/ceramic, 2 surfaces	\$ 100.00*
D6609	Retainer onlay, porcelain/ceramic, 3 or more surfaces	\$ 105.00*
D6610	Retainer onlay, cast high noble metal, 2 surfaces	\$ 100.00*
D6611	Retainer onlay, cast high noble metal, 3 or more surfaces	\$ 100.00*
D6612	Retainer onlay, cast base metal, 2 surfaces	\$ 90.00
D6613	Retainer onlay, cast base metal, 3 or more surfaces	\$ 95.00
D6614	Retainer onlay, cast noble metal, 2 surfaces	\$ 90.00*
D6615	Retainer onlay, cast noble metal 3 or more surfaces	\$ 95.00*



# LS100 Plan

ADA Code	Procedure	Member pays
<b>Prostodontics - fixed (continued)</b>		
D6634	Retainer onlay, titanium	\$ 95.00*
D6710	Retainer crown, indirect resin based composite	\$ 60.00*
D6720	Retainer crown, resin with high noble metal	\$ 70.00*
D6721	Retainer crown, resin with predominantly base metal	\$ 70.00*
D6722	Retainer crown, resin with noble metal	\$ 70.00*
D6740	Retainer crown, porcelain/ceramic	\$ 70.00*
D6750	Retainer crown, porcelain fused to high noble metal	\$ 70.00*
D6751	Retainer crown, porcelain fused to predominantly base metal	\$ 70.00*
D6752	Retainer crown, porcelain fused to noble metal	\$ 70.00*
D6780	Retainer crown, 3/4 cast high noble metal	\$ 70.00*
D6781	Retainer crown, 3/4 cast predominantly base metal	\$ 70.00
D6782	Retainer crown, 3/4 cast noble metal	\$ 70.00*
D6783	Retainer crown, 3/4 porcelain/ceramic	\$ 70.00*
D6790	Retainer crown, full cast high noble metal	\$ 70.00*
D6791	Retainer crown, full cast predominantly base metal	\$ 70.00
D6792	Retainer crown, full cast noble metal	\$ 70.00*
D6793	Provisional retainer crown	\$ 40.00
D6794	Retainer crown, titanium	\$ 70.00*
D6930	Recement fixed partial denture	no charge
D6940	Stress breaker	\$ 10.00
D6970	Post & core in addition to FPD retainer, indirect	\$ 20.00*
D6972	Prefabricated post & core in add. to FPD retainer	\$ 20.00
D6973	Core buildup for retainer, including any pins	\$ 20.00
D6976	Each additional indirectly fabricated post/same tooth	\$ 20.00*
D6977	Each additional prefabricated post, same tooth	\$ 20.00
D6980	Fixed partial denture repair, by report	\$ 15.00
<b>Oral and maxillofacial surgery</b>		
D7111	Extraction, coronal remnants, deciduous tooth	no charge
D7140	Extraction, erupted tooth or exposed root	no charge
D7210	Surgical removal of erupted tooth	\$ 15.00
D7220	Removal of impacted tooth, soft tissue	\$ 45.00
D7230	Removal of impacted tooth, partially bony	\$ 55.00
D7240	Removal of impacted tooth, completely bony	\$ 80.00
D7241	Removal impacted tooth, complete bony, complication	\$ 130.00
D7250	Surgical removal residual tooth roots, cutting proc.	\$ 40.00
D7261	Primary closure of a sinus perforation	\$ 95.00
D7270	Tooth reimplantation/stabilization, accident	\$ 55.00
D7280	Surgical access of an unerupted tooth	\$ 95.00
D7282	Mobilization of erupted/malpositioned tooth	\$ 30.00
D7283	Placement, device to facilitate eruption, impaction	\$ 30.00
D7285	Biopsy of oral tissue, hard (bone, tooth)	no charge
D7286	Biopsy of oral tissue, soft	no charge
D7287	Exfoliative cytological sample collection	\$ 10.00
D7288	Brush biopsy, transepithelial sample collection	\$ 10.00
D7310	Alveoloplasty with extractions, 4+ teeth, quadrant	\$ 30.00
D7311	Alveoloplasty with extractions, 1-3 teeth, quadrant	\$ 30.00
D7320	Alveoloplasty, w/o extractions, 4+ teeth, quadrant	\$ 35.00
D7321	Alveoloplasty, w/o extractions, 1-3 teeth, quadrant	\$ 50.00
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$ 40.00
D7350	Vestibuloplasty, ridge extension	\$ 55.00
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25	\$ 45.00
D7451	Removal, benign odontogenic cyst/tumor, over 1.25	\$ 90.00
D7460	Removal, benign nonodontogenic cyst/tumor, to 1.25	\$ 50.00
D7461	Removal, benign nonodontogenic cyst/tumor, 1.25+	\$ 70.00
D7471	Removal of lateral exostosis, maxilla or mandible	\$ 55.00
D7472	Removal of torus palatinus	\$ 40.00
D7473	Removal of torus mandibularis	\$ 40.00

# LS100 Plan

ADA Code	Procedure	Member pays
<b>Oral and maxillofacial surgery (continued)</b>		
D7485	Surgical reduction of osseous tuberosity	\$ 30.00
D7510	Incision & drainage of abscess, intraoral soft tissue	\$ 5.00
D7511	Incision/drainage, abscess, intraoral soft, complicated	\$ 10.00
D7520	Incision & drainage, abscess, extraoral soft tissue	\$ 5.00
D7521	Incision/drainage, abscess, extraoral soft, complicate	\$ 8.00
D7530	Remove foreign body, mucosa, skin, tissue	\$ 10.00
D7560	Maxillary sinusotomy, remove th. frag./foreign body	\$ 25.00
D7960	Frenulectomy (frenectomy or frenotomy), sep. proc.	no charge
D7963	Frenuloplasty	no charge
D7970	Excision of hyperplastic tissue, per arch	\$ 40.00
D7971	Excision of pericoronal gingival	\$ 30.00
<b>Adjunctive general services</b>		
D9110	Palliative (emergency) treatment, minor procedure	\$ 5.00
D9120	Fixed partial denture sectioning	no charge
D9210	Local anesthesia not with operative/surgical proced.	no charge
D9211	Regional block anesthesia	no charge
D9212	Trigeminal division block anesthesia	no charge
D9215	Local anesthesia with operative/surgical procedure	no charge
<b>** GUIDELINE:</b>		
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 is 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.		
D9223	Deep sedation/general anesthesia – each 15 minute increment	\$ 165.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$ 15.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	\$ 100.00
D9248	Non-intravenous conscious sedation	\$ 100.00
D9310	Consultation, other than requesting dentist	no charge
D9430	Office visit, observation, regular hrs., no other serv.	no charge
D9440	Office visit, after regularly scheduled hours	\$ 25.00
D9450	Case presentation, detailed & extensive treatment	no charge
D9630	Other drugs and/or medicaments, by report	\$ 15.00
D9910	Application of desensitizing medicament	no charge
D9911	Application of desensitizing resin, per tooth	no charge
D9930	Treatment of complications, post surgical, unusual	no charge
D9940	Occlusal guard, by report	\$ 100.00
D9942	Repair and/or reline of occlusal guard	\$ 40.00
D9950	Occlusion analysis, mounted case	no charge
D9951	Occlusal adjustment, limited	\$ 10.00
D9952	Occlusal adjustment, complete	\$ 10.00
D9971	Odontoplasty 1-2 teeth	\$ 5.00
D9972	External bleaching – per arch	\$ 175.00
	Broken appointment, less than 24 hour notice	\$ 10.00
	Office visit, per visit	no charge
<b>Orthodontic Services</b>		
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	\$ 100.00
D0470	Diagnostic casts for orthodontic purposes	\$ 75.00
D9310	Initial consultation for orthodontic purposes	\$ 0.00
D8010	Limited orthodontic treatment of the primary dentition	\$1,300.00
D8020	Limited orthodontic treatment of the transitional dentition	\$1,300.00
D8030	Limited orthodontic treatment of the adolescent dentition	\$1,300.00
D8040	Limited orthodontic treatment of the adult dentition	\$1,300.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$ 500.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$ 500.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1,550.00

# LS100 Plan

ADA Code	Procedure	Member pays
<b>Orthodontic Services (continued)</b>		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,550.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$1,695.00
D8210	Removable appliance therapy	\$ 350.00
D8220	Fixed appliance therapy	\$ 350.00
D8660	Pre-orthodontic treatment visits	\$ 0.00
D8670	Periodic orthodontic visits (as part of contract)	\$ 0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$ 250.00
	Broken appointment (less than 24 hour notice)	\$ 20.00

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. When you receive services from a Dental Specialist utilizing the proper referral process, the Member Co-Payments listed in this Copayment Schedule will apply.

### 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

### 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 planning 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 relines 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).

## 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 your assigned 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.

This disclosure is only a summary of the dental plan. The dental plan contract and evidence of coverage must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract and evidence of coverage is available on request for examination at the administrative office of LIBERTY Dental Plan of California, Inc..

Underwritten by LIBERTY Dental Plan of California, Inc.

