



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - IEHP Silver AIAN HMO
Individual Out of Pocket Maximum: \$11,650 per 2027 Calendar Year
Family Out of Pocket Maximum: \$23,300 per 2027 Calendar Year

- ✓ Members must visit a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will determine a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the recommended covered services are medically necessary and outside the scope of a general dentist.
- ✓ This Benefit Schedule represents the Children's Dental HMO benefits covered as part of your Health Plan offered through IEHP Covered. Any Co-payment for covered dental services will accrue towards the Health Plan's 2027 Plan Year Out-of-Pocket Maximum (which is provided above for your reference). To verify your Out-of-Pocket Maximum you can refer to your Health Plan's Evidence of Coverage booklet, visit your health plan's website at www.iehp.org or call Member Services at 1-855-433-4347 (toll-free).
- ✓ Once your Out-of-Pocket costs for all Medical and Dental covered services reach the combined Out-of-Pocket Maximum, you cannot be charged for covered dental services you receive for the remainder of the 2027 year. The LIBERTY Dental Plan contracted dental office will be paid for covered services as contracted directly by LIBERTY. Charges for optional and non-covered services are not included in the calculation for the combined out-of-pocket maximum and would remain your financial responsibility. In a plan with two or more members, the first family Member to meet the individual Out-of-Pocket Maximum cannot be charged for covered services for the remainder of the 2027 year. The family Out-of-Pocket Maximum is met by combining eligible expenses of two or more covered family Members.
- ✓ Member Co-payments are payable to the dental office at the time services are rendered.
- ✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations and must be determined to be medically necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- ✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Patient Responsibility	Limitation
Diagnostic Services			
D0120	Periodic oral evaluation	no charge	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	no charge	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	no charge	
D0150	Comprehensive oral evaluation	no charge	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	up to 6 of (D0170, D0171) in a 3 month period, no more than 12 in 12 months
D0171	Re-evaluation, post operative office visit	no charge	
D0180	Comprehensive periodontal evaluation	no charge	
D0190	Screening of a patient	not covered	only billed as D0150
D0191	Assessment of a patient	not covered	
D0210	Intraoral, comprehensive series of radiographic images	no charge	1 of (D0210, D0709) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	20 of (D0220, D0230, D0707) 12 months, per provider
D0230	Intraoral, periapical, each add'l radiographic image	no charge	
D0240	Intraoral, occlusal radiographic image	no charge	2 of (D0240, D0706) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	
D0251	Extra-oral posterior dental radiographic image	no charge	1 (D0251, D0705) per date of service
D0270	Bitewing, single radiographic image	no charge	1 of (D0270, D0708) per date of service
D0272	Bitewings, two radiographic images	no charge	1 (D0272) every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	downcode to D0270 and D0272
D0274	Bitewings, four radiographic images	no charge	1 (D0274) every 6 months per provider, age 10 and over
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	downcode to D0274
D0310	Sialography	no charge	
D0320	TMJ arthrogram, including injection	no charge	3 (D0320) per date of service
D0322	Tomographic survey	no charge	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	no charge	1 of (D0330, D0701) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	2 of (D0340, D0702) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	4 of (D0350, D0703) per date of service
D0396	3D printing of a 3D dental surface scan	no charge	
D0419	Assessment of salivary flow by measurement	not covered	
D0431	Adjunctive pre-diagnostic test	not covered	
D0460	Pulp vitality tests	no charge	
D0470	Diagnostic casts	no charge	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent dentition
D0502	Other oral pathology procedures, by report	no charge	
D0601	Caries risk assessment and documentation, low risk	no charge	
D0602	Caries risk assessment and documentation, moderate risk	no charge	
D0603	Caries risk assessment and documentation, high risk	no charge	
D0701	Panoramic radiographic image, image capture only	no charge	1 of (D0330, D0701) every 36 months per provider
D0702	2-D cephalometric radiographic image, image capture only	no charge	2 of (D0340, D0702) every 12 months per provider
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	no charge	4 of (D0350, D0703) per date of service
D0705	Extra-oral posterior dental radiographic image, image capture only	no charge	1 of (D0251, D0705) per date of service
D0706	Intraoral, occlusal radiographic image, image capture only	no charge	2 of (D0240, D0706) every 6 months per provider
D0707	Intraoral, periapical radiographic image, image capture only	no charge	20 of (D0220, D0230, D0707) every 12 months, per provider
D0708	Intraoral, bitewing radiographic image, image capture only	no charge	1 of (D0270, D0708) per date of service
D0709	Intraoral, comprehensive series of radiographic images, image capture only	no charge	1 of (D0210, D0709) every 36 months per provider
D0801	3D intraoral surface scan, direct	no charge	
D0802	3D dental surface scan, indirect	no charge	
D0803	3D facial surface scan, direct	no charge	
D0804	3D facial surface scan, indirect	no charge	
D0999	Unspecified diagnostic procedure, by report	no charge	
Preventive Services			
D1110	Prophylaxis, adult	no charge	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	no charge	
D1206	Topical application of fluoride varnish	no charge	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	no charge	
D1310	Nutritional counseling for control of dental disease	no charge	
D1320	Tobacco counseling, control/prevention oral disease	no charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	no charge	
D1330	Oral hygiene instruction	no charge	
D1351	Sealant, per tooth	no charge	1 of (D1351) every 36 months 1st, 2nd, 3rd molars
D1353	Sealant repair, per tooth	no charge	1 (D1353) every 36 months 1st, 2nd, 3rd molars
D1354	Application of caries arresting medicament, per tooth	no charge	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first
D1355	Caries preventive medicament application, per tooth	no charge	1 (D1355) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient, under age 18
D1516	Space maintainer, fixed, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1517	Space maintainer, fixed, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1520	Space maintainer, removable, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient under age 18



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Preventive Services (continued)			
D1526	Space maintainer, removable, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1527	Space maintainer, removable, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	no charge	1 (D1551) every 12 months under age 18
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	no charge	1 (D1552) every 12 months under age 18
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	no charge	1 (D1553) per quad every 12 months under age 18
D1556	Removal of fixed unilateral space maintainer, per quadrant	no charge	
D1557	Removal of fixed bilateral space maintainer, maxillary	no charge	
D1558	Removal of fixed bilateral space maintainer, mandibular	no charge	
D1575	Distal shoe space maintainer, fixed, per quadrant	no charge	
Restorative Services			
D2140	Amalgam, one surface, primary or permanent	\$25	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months
D2150	Amalgam, two surfaces, primary or permanent	\$30	permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months

D2160	Amalgam, three surfaces, primary or permanent	\$40	
D2161	Amalgam, four or more surfaces, primary or permanent	\$45	
D2330	Resin-based composite, one surface, anterior	\$30	
D2331	Resin-based composite, two surfaces, anterior	\$45	
D2332	Resin-based composite, three surfaces, posterior	\$55	
D2335	Resin-based composite, four or more surfaces	\$60	
D2390	Resin-based composite crown, anterior	\$50	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	\$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2392	Resin-based composite, two surfaces, posterior	\$40	
D2393	Resin-based composite, three surfaces, posterior	\$50	
D2394	Resin-based composite, four or more surfaces, posterior	\$70	
D2542	Onlay, metallic, two surfaces	not covered	
D2543	Onlay, metallic, three surfaces	not covered	
D2544	Onlay, metallic, four or more surfaces	not covered	
D2642	Onlay, porcelain/ceramic, two surfaces	not covered	
D2643	Onlay, porcelain/ceramic, three surfaces	not covered	
D2644	Onlay, porcelain/ceramic, four or more surfaces	not covered	
D2662	Onlay, resin-based composite, two surfaces	not covered	
D2663	Onlay, resin-based composite, three surfaces	not covered	
D2664	Onlay, resin-based composite, four or more surfaces	not covered	
D2710	Crown, resin-based composite (indirect)	\$140	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D2712	Crown, % resin-based composite (indirect)	\$190	
D2720	Crown, resin with high noble metal	not covered	
D2721	Crown, resin with predominantly base metal	\$300	
D2722	Crown, resin with noble metal	not covered	
D2740	Crown, porcelain/ceramic	\$300	
D2750	Crown, porcelain fused to high noble metal	not covered	
D2751	Crown, porcelain fused to predominantly base metal	\$300	
D2752	Crown, porcelain fused to noble metal	not covered	
D2753	Crown, porcelain fused to titanium and titanium alloys	not covered	
D2780	Crown, % cast high noble metal	not covered	
D2781	Crown, % cast predominantly base metal	\$300	
D2782	Crown, % cast noble metal	not covered	
D2783	Crown, % porcelain/ceramic	\$310	
D2790	Crown, full cast high noble metal	not covered	
D2791	Crown, full cast predominantly base metal	\$300	
D2792	Crown, full cast noble metal	not covered	
D2794	Crown, titanium and titanium alloys	not covered	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$25	1 (D2910) per tooth every 12 months, per provider
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$25	
D2920	Re-cement or re-bond crown	\$25	after 12 months of initial placement with same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	\$45	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	\$120	1 of (D2928, D2931) per tooth every 36 months
D2929	Prefabricated porcelain/ceramic crown, primary tooth	\$95	1 of (D2929, D2930) per tooth every 12 months
D2930	Prefabricated stainless steel crown, primary tooth	\$65	
D2931	Prefabricated stainless steel crown, permanent tooth	\$75	1 of (D2928, D2931) per tooth every 36 months
D2932	Prefabricated resin crown	\$75	primary - 1 of (D2932, D2933) per tooth every 12 months
D2933	Prefabricated stainless steel crown with resin window	\$80	permanent - 1 of (D2932, D2933) per tooth every 36 months
D2940	Placement of interim direct restoration	\$25	1 (D2940) per tooth every 6 months, per provider
D2949	Restorative foundation for an indirect restoration	\$45	
D2950	Core buildup, including any pins when required	\$20	
D2951	Pin retention, per tooth, in addition to restoration	\$25	1 (D2951) per tooth
D2952	Post and core in addition to crown, indirectly fabricated	\$100	1 (D2952) per tooth
D2953	Each additional indirectly fabricated post, same tooth	\$30	
D2954	Prefabricated post and core in addition to crown	\$90	1 (D2954) per tooth
D2955	Post removal	\$60	
D2957	Each additional prefabricated post, same tooth	\$35	
D2971	Additional procedure to customize new crown, existing partial denture frame	\$35	
D2976	Band stabilization, per tooth	\$40	
D2980	Crown repair necessitated by restorative material failure	\$50	after 12 months of initial crown placement with same provider
D2989	Excavation of a tooth resulting in the determination of non-restorability	\$50	
D2991	Application of hydroxyapatite regeneration medicament, per tooth	no charge	
D2999	Unspecified restorative procedure, by report	\$40	
Endodontic Services			
D3110	Pulp cap, direct (excluding final restoration)	\$20	
D3120	Pulp cap, indirect (excluding final restoration)	\$25	
D3220	Therapeutic pulpotomy (excluding final restoration)	\$40	1 (D3220) per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	\$40	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	\$60	1 (D3222) per tooth
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$55	1 of (D3230, D3240) per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	\$55	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$195	1 of (D3310, D3320, D3330) per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$235	



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Endodontic Services (continued)			
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$300	1 of (D3310, D3320, D3330) per tooth
D3331	Treatment of root canal obstruction; non-surgical access	\$50	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	
D3333	Internal root repair of perforation defects	\$80	
D3346	Retreatment of previous root canal therapy, anterior	\$240	1 of (D3346-D3348) after 12 months of initial treatment
D3347	Retreatment of previous root canal therapy, premolar	\$295	
D3348	Retreatment of previous root canal therapy, molar	\$350	
D3351	Apexification/recalcification, initial visit	\$85	1 (D3351) per tooth
D3352	Apexification/recalcification, interim medication replacement	\$45	1 (D3352) per tooth
D3353	Apexification/recalcification, final visit	not covered	
D3410	Apicoectomy, anterior	\$240	
D3421	Apicoectomy, premolar (first root)	\$250	
D3425	Apicoectomy, molar (first root)	\$275	
D3426	Apicoectomy, (each additional root)	\$110	
D3428	Bone graft in conjunction with periradicular surgery, per tooth, single site	\$350	
D3429	Bone graft in conjunction with periradicular surgery, each add'l tooth, same site	\$350	
D3430	Retrograde filling, per root	\$90	
D3431	Biologic materials, soft osseous tissue regeneration with periradicular surgery	\$80	
D3432	Guided tissue regeneration, per site, with periradicular surgery	not covered	
D3450	Root amputation, per root	not covered	
D3471	Surgical repair of root resorption, anterior	\$160	
D3472	Surgical repair of root resorption, premolar	\$160	
D3473	Surgical repair of root resorption, molar	\$160	
D3910	Surgical procedure for isolation of tooth with rubber dam	\$30	
D3920	Hemisection, not including root canal therapy	not covered	
D3950	Canal preparation and fitting of prefabricated dowel or post	not covered	
D3999	Unspecified endodontic procedure, by report	\$100	
Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$150	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$50	
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	

D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	
D4249	Clinical crown lengthening, hard tissue	\$165	
D4260	Osseous surgery, four or more teeth per quadrant	\$265	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4261	Osseous surgery, one to three teeth per quadrant	\$140	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	\$80	
D4266	Guided tissue regeneration, natural teeth, resorbable barrier, per site	not covered	
D4267	Guided tissue regeneration, natural teeth, non-resorbable barrier, per site	not covered	
D4270	Pedicle soft tissue graft procedure	not covered	
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	
D4275	Non-autogenous connective tissue graft, first tooth	not covered	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4286	Removal of non-resorbable barrier	not covered	
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	\$55	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$30	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$40	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	\$40	
D4381	Localized delivery of antimicrobial agent/per tooth	\$10	
D4910	Periodontal maintenance	\$30	1 (D4910) every 3 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	\$15	1 (D4920) per patient per provider, age 13 and over
D4999	Unspecified periodontal procedure, by report	\$350	
Removable Prosthodontic Services			
D5110	Complete denture, maxillary	\$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5120	Complete denture, mandibular	\$300	
D5130	Immediate denture, maxillary	\$300	1 (D5130) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5140	Immediate denture, mandibular	\$300	1 (D5140) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5211	Maxillary partial denture, resin base	\$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5212	Mandibular partial denture, resin base	\$300	
D5213	Maxillary partial denture, cast metal, resin base	\$335	
D5214	Mandibular partial denture, cast metal, resin base	\$335	
D5221	Immediate maxillary partial denture, resin base	\$275	1 of (D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5222	Immediate mandibular partial denture, resin base	\$275	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$330	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$330	
D5225	Maxillary partial denture, flexible base	not covered	
D5226	Mandibular partial denture, flexible base	not covered	
D5227	Immediate maxillary partial denture, flexible base	not covered	
D5228	Immediate mandibular partial denture, flexible base	not covered	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	not covered	
D5286	Removable unilateral partial denture, one piece resin, per quadrant	not covered	
D5410	Adjust complete denture, maxillary	\$20	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	\$20	
D5421	Adjust partial denture, maxillary	\$20	
D5422	Adjust partial denture, mandibular	\$20	
D5511	Repair broken complete denture base, mandibular	\$40	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	\$40	1 (D5512) per date of service per provider, 2 every 12 months per provider



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Removable Prosthodontic Services (continued)			
D5520	Replace missing or broken teeth, complete denture, per tooth	\$40	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin partial denture base, mandibular	\$40	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin partial denture base, maxillary	\$40	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast partial framework, mandibular	\$40	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast partial framework, maxillary	\$40	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken retentive clasping materials, per tooth	\$50	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace missing or broken teeth, partial denture, per tooth	\$35	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture, per tooth	\$35	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	\$60	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	
D5710	Rebase complete maxillary denture	not covered	
D5711	Rebase complete mandibular denture	not covered	
D5720	Rebase maxillary partial denture	not covered	
D5721	Rebase mandibular partial denture	not covered	
D5730	Reline complete maxillary denture, direct	\$60	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, direct	\$60	
D5740	Reline maxillary partial denture, direct	\$60	
D5741	Reline mandibular partial denture, direct	\$60	
D5750	Reline complete maxillary denture, indirect	\$90	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5751	Reline complete mandibular denture, indirect	\$90	
D5760	Reline maxillary partial denture, indirect	\$80	
D5761	Reline mandibular partial denture, indirect	\$80	
D5850	Tissue conditioning, maxillary	\$30	2 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	\$30	2 (D5851) every 36 months
D5862	Precision attachment, by report	\$90	
D5863	Overdenture, complete, maxillary, natural tooth borne	\$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5864	Overdenture, partial, maxillary, natural tooth borne	\$300	
D5865	Overdenture, complete, mandibular, natural tooth borne	\$300	
D5866	Overdenture, partial, mandibular, natural tooth borne	\$300	
D5876	Add metal substructure to acrylic complete denture, per arch	not covered	
D5899	Unspecified removable prosthodontic procedure, by report	\$350	
Maxillofacial Prosthetic Services			
D5909	Maxillary guidance prosthesis with guide flange	\$350	
D5911	Facial moulage (sectional)	\$285	
D5912	Facial moulage (complete)	\$350	
D5913	Nasal prosthesis	\$350	
D5914	Auricular prosthesis	\$350	
D5915	Orbital prosthesis	\$350	
D5916	Ocular prosthesis	\$350	
D5919	Facial prosthesis	\$350	
D5922	Nasal septal prosthesis	\$350	
D5923	Ocular prosthesis, interim	\$350	
D5924	Cranial prosthesis	\$350	
D5925	Facial augmentation implant prosthesis	\$200	
D5926	Nasal prosthesis, replacement	\$200	
D5927	Auricular prosthesis, replacement	\$200	

D5928	Orbital prosthesis, replacement	\$200	
D5929	Facial prosthesis, replacement	\$200	
D5930	Maxillary guidance prosthesis without guide flange	\$350	
D5931	Obturator prosthesis, surgical	\$350	
D5932	Obturator prosthesis, definitive	\$350	
D5933	Obturator prosthesis, modification	\$150	2 (D5933) every 12 months
D5934	Mandibular guidance prosthesis with guide flange	\$350	
D5935	Mandibular guidance prosthesis without guide flange	\$350	
D5936	Obturator prosthesis, interim	\$350	
D5937	Trismus appliance (not for TMD treatment)	\$85	
D5938	Resection prosthesis, maxillary complete removable	\$350	
D5939	Resection prosthesis, mandibular complete removable	\$350	
D5940	Resection prosthesis, maxillary partial removable	\$350	
D5941	Resection prosthesis, mandibular partial removable	\$350	
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis, arch	\$350	
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis, arch	\$350	
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis, partial, arch	\$350	
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis, partial, arch	\$350	
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis, arch	\$350	
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis, arch	\$350	
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis, partial, arch	\$350	
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis, partial, arch	\$350	
D5951	Feeding aid	\$135	under age 18
D5952	Speech aid prosthesis, pediatric	\$350	under age 18
D5953	Speech aid prosthesis, adult	\$350	age 18 and over
D5954	Palatal augmentation prosthesis	\$135	
D5955	Palatal lift prosthesis, definitive	\$350	
D5958	Palatal lift prosthesis, interim	\$350	
D5959	Palatal lift prosthesis, modification	\$145	2 (D5959) every 12 months
D5960	Speech aid prosthesis, modification	\$145	2 (D5960) every 12 months
D5982	Surgical stent, for soft tissue healing	\$70	
D5983	Radiation carrier	\$55	
D5984	Radiation shield	\$85	
D5985	Radiation cone locator	\$135	
D5986	Fluoride gel carrier	\$35	
D5987	Commissure splint	\$85	



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Maxillofacial Prosthetic Services (continued)			
D5988	Surgical splint	\$95	
D5991	Vesiculobullous disease medicament carrier	\$70	
D5999	Unspecified maxillofacial prosthesis, by report	\$350	
Implant Services			
D6010	Surgical placement of implant body, endosteal	\$350	
D6011	Surgical access to an implant body (second state implant surgery)	\$350	
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	\$350	
D6013	Surgical placement of mini implant	\$350	
D6040	Surgical placement: eposteal implant	\$350	
D6049	Scaling and debridement in the presence of peri-implantitis inflammation, single implant	\$35	
D6050	Surgical placement: transosteal implant	\$350	
D6055	Connecting bar, implant supported or abutment supported	\$350	
D6056	Prefabricated abutment, includes modification and placement	\$135	
D6057	Custom fabricated abutment, includes placement	\$180	
D6058	Abutment supported porcelain/ceramic crown	\$320	
D6059	Abutment supported porcelain fused to high noble crown	\$315	
D6060	Abutment supported porcelain fused to base metal crown	\$295	
D6061	Abutment supported porcelain fused to noble metal crown	\$300	
D6062	Abutment supported cast metal crown, high noble	\$315	
D6063	Abutment supported cast metal crown, base metal	\$300	
D6064	Abutment supported cast metal crown, noble metal	\$315	
D6065	Implant supported porcelain/ceramic crown	\$340	
D6066	Implant supported crown, porcelain fused to high noble alloys	\$335	
D6067	Implant supported crown, high noble alloys	\$340	
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$320	
D6069	Abutment supported retainer, metal FPD, high noble	\$315	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	\$290	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	\$300	
D6072	Abutment supported retainer, cast metal FPD, high noble	\$315	
D6073	Abutment supported retainer, cast metal FPD, base metal	\$290	
D6074	Abutment supported retainer, cast metal FPD, noble	\$320	
D6075	Implant supported retainer for ceramic FPD	\$335	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	\$330	
D6077	Implant supported retainer for metal FPD, high noble alloys	\$350	
D6080	Implant maintenance procedures, full arch fixed hybrid prosthesis removed/reinserted, including cleansing	\$30	
D6081	Scaling and debridement in the presence of inflammation or mucositis, of a single implant	\$30	
D6082	Implant supported crown, porcelain fused to predominantly base alloys	\$335	
D6083	Implant supported crown, porcelain fused to noble alloys	\$335	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	\$335	
D6085	Interim implant crown	\$300	
D6086	Implant supported crown, predominantly base alloys	\$340	
D6087	Implant supported crown, noble alloys	\$340	
D6088	Implant supported crown, titanium and titanium alloys	\$340	
D6089	Accessing and retorquing loose implant screw, per screw	\$60	
D6090	Repair of implant/abutment, supported prosthesis	\$65	
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	\$40	
D6092	Re-cement or re-bond implant/abutment supported crown	\$25	
D6093	Re-cement or re-bond implant/abutment supported FPD	\$35	
D6094	Abutment supported crown, titanium, and titanium alloys	\$295	
D6096	Remove broken implant retaining screw	\$60	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	\$315	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	\$330	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	\$330	
D6100	Surgical removal of implant body	\$110	
D6105	Removal of implant body not requiring bone removal or flap elevation	\$110	
D6110	Implant/abutment supported removable denture, maxillary	\$350	
D6111	Implant/abutment supported removable denture, mandibular	\$350	
D6112	Implant/abutment supported removable denture, partial, maxillary	\$350	
D6113	Implant/abutment supported removable denture, partial, mandibular	\$350	
D6114	Implant/abutment supported fixed denture, maxillary	\$350	
D6115	Implant/abutment supported fixed denture, mandibular	\$350	
D6116	Implant/abutment supported fixed denture for partial, maxillary	\$350	
D6117	Implant/abutment supported fixed denture for partial, mandibular	\$350	
D6118	Implant/abutment supported interim fixed denture, mandibular	\$350	
D6119	Implant/abutment supported interim fixed denture, maxillary	\$350	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	\$330	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	\$350	

Only a Plan Benefit when exceptional medical conditions are met

D6122	Implant supported retainer for metal FPD, noble alloys	\$350
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	\$350
D6180	Implant maintenance procedures, full arch fixed hybrid prosthesis is not removed, including cleansing	\$30
D6190	Radiographic/surgical implant index, by report	\$75
D6191	Semi-precision abutment, placement	\$350
D6192	Semi-precision attachment, placement	\$350
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	\$265
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	\$315
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	\$95
D6198	Remove interim implant component	\$110
D6199	Unspecified implant procedure, by report	\$350
Fixed Prosthodontic Services		
D6205	Pontic, indirect resin based composite	not covered
D6210	Pontic, cast high noble metal	not covered



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation	
Fixed Prosthodontic Services				
D6211	Pontic, cast predominantly base metal	\$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6212	Pontic, cast noble metal	not covered		
D6214	Pontic, titanium, and titanium alloys	not covered		
D6240	Pontic, porcelain fused to high noble metal	not covered		
D6241	Pontic, porcelain fused to predominantly base metal	\$300		
D6242	Pontic, porcelain fused to noble metal	not covered		
D6243	Pontic, porcelain fused to titanium and titanium alloys	not covered		
D6245	Pontic, porcelain/ceramic	\$300		
D6250	Pontic, resin with high noble metal	not covered		
D6251	Pontic, resin with predominantly base metal	\$300		
D6252	Pontic, resin with noble metal	not covered		
D6280	Implant maintenance procedures, full arch removable implant/abutment supported denture, cleansing, per arch	\$20		
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	not covered		
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered		
D6608	Retainer onlay, porcelain/ceramic, two surfaces	not covered		
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	not covered		
D6610	Retainer onlay, cast high noble metal, two surfaces	not covered		
D6611	Retainer onlay, cast high noble metal, three or more surfaces	not covered		
D6612	Retainer onlay, cast base metal, two surfaces	not covered		
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered		
D6614	Retainer onlay, cast noble metal, two surfaces	not covered		
D6615	Retainer onlay, cast noble metal three or more surfaces	not covered		
D6634	Retainer onlay, titanium	not covered		
D6710	Retainer crown, indirect resin based composite	not covered		
D6720	Retainer crown, resin with high noble metal	not covered		
D6721	Retainer crown, resin with predominantly base metal	\$300		
D6722	Retainer crown, resin with noble metal	not covered		
D6740	Retainer crown, porcelain/ceramic	\$300		
D6750	Retainer crown, porcelain fused to high noble metal	not covered		
D6751	Retainer crown, porcelain fused to predominantly base metal	\$300		
D6752	Retainer crown, porcelain fused to noble metal	not covered		
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	not covered		
D6781	Retainer crown, % cast predominantly base metal	\$300		
D6782	Retainer crown, % cast noble metal	not covered		
D6783	Retainer crown, % porcelain/ceramic	\$300		
D6784	Retainer crown %, titanium and titanium alloys	\$300		
D6791	Retainer crown, full cast predominantly base metal	\$300		
D6794	Retainer crown, titanium and titanium alloys	not covered		
D6930	Re-cement or re-bond fixed partial denture	\$40		
D6980	Fixed partial denture repair, restorative material failure	\$95		
D6999	Unspecified fixed prosthodontic procedure, by report	\$350		
Oral & Maxillofacial Services				
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists				
D7111	Extraction, coronal remnants, primary tooth	\$40	1 (D7259) per tooth in a lifetime; limited to teeth #17 and #32. Inclusive with D7241. Must be performed by licensed Oral Surgeon.	
D7140	Extraction, erupted tooth or exposed root	\$65		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	\$120		
D7220	Removal of impacted tooth, soft tissue	\$95		
D7230	Removal of impacted tooth, partially bony	\$145		
D7240	Removal of impacted tooth, completely bony	\$160		
D7241	Removal impacted tooth, complete bony, complication	\$175		
D7250	Removal of residual tooth roots (cutting procedure)	\$80		
D7252	Partial extraction for immediate implant placement	\$80		
D7259	Nerve dissection	\$280		
D7260	Oroantral fistula closure	\$280		
D7261	Primary closure of a sinus perforation	\$285		
D7270	Tooth reimplantation and/or stabilization, accident	\$185	1 (D7270) per arch	
D7280	Exposure of an unerupted tooth	\$220		
D7283	Placement, device to facilitate eruption, impaction	\$85	1 (D7285) per arch per date of service up to 3 (D7286) per date of service	
D7284	Excisional biopsy of minor salivary glands	\$115		
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$180		
D7286	Incisional biopsy of oral tissue, soft	\$110		
D7287	Exfoliative cytological sample collection	not covered	1 (D7290) per arch, for active orthodontic treatment only 1 (D7291) per arch, for active orthodontic treatment only	
D7288	Brush biopsy, transepithelial sample collection	not covered		
D7290	Surgical repositioning of teeth	\$185	1 (D7290) per arch, for active orthodontic treatment only 1 (D7291) per arch, for active orthodontic treatment only	
D7291	Transseptal fibrotomy/supra crestal fibrotomy, by report	\$80		
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$85	1 (D7340) per arch every 5 year period 1 (D7350) per arch	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$50		
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$120		
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$65		
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$350		
D7350	Vestibuloplasty, ridge extension	\$350		
D7410	Excision of benign lesion, up to 1.25 cm	\$75		
D7411	Excision of benign lesion, greater than 1.25 cm	\$115		
D7412	Excision of benign lesion, complicated	\$175		
D7413	Excision of malignant lesion, up to 1.25 cm	\$95		
D7414	Excision of malignant lesion, greater than 1.25 cm	\$120		
D7415	Excision of malignant lesion, complicated	\$255		
D7440	Excision of malignant tumor, up to 1.25 cm	\$105	1 (D7340) per arch every 5 year period 1 (D7350) per arch	
D7441	Excision of malignant tumor, greater than 1.25 cm	\$185		
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	\$180		
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	\$330		
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	\$155		
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	\$250		



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Oral & Maxillofacial Services (continued)			
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$40	
D7471	Removal of lateral exostosis, maxilla or mandible	\$140	1 (D7471) per quadrant
D7472	Removal of torus palatinus	\$145	1 (D7472) per lifetime
D7473	Removal of torus mandibularis	\$140	1 (D7473) per quadrant
D7485	Reduction of osseous tuberosity	\$105	1 (D7485) per quadrant
D7490	Radical resection of maxilla or mandible	\$350	
D7509	Marsupialization of odontogenic cyst	\$180	
D7510	Incision & drainage of abscess, intraoral soft tissue	\$70	1 (D7510) per quadrant, same date of service
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	\$70	1 (D7511) per quadrant, same date of service
D7520	Incision & drainage of abscess, extraoral soft tissue	\$70	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	\$80	
D7530	Remove foreign body, mucosa, skin, tissue	\$45	1 (D7530) per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$75	1 (D7540) per date of service
D7550	Partial osteotomy/sequestrectomy for removal of non-vital bone	\$125	1 (D7550) per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$235	
D7610	Maxilla, open reduction (teeth immobilized, if present)	\$140	
D7620	Maxilla, closed reduction (teeth immobilized, if present)	\$250	
D7630	Mandible, open reduction (teeth immobilized, if present)	\$350	
D7640	Mandible, closed reduction (teeth immobilized, if present)	\$350	
D7650	Malar and/or zygomatic arch, open reduction	\$350	
D7660	Malar and/or zygomatic arch, closed reduction	\$350	
D7670	Alveolus, closed reduction, may include stabilization of teeth	\$170	
D7671	Alveolus, open reduction, may include stabilization of teeth	\$230	
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	\$350	
D7710	Maxilla, open reduction	\$110	
D7720	Maxilla, closed reduction	\$180	
D7730	Mandible, open reduction	\$350	
D7740	Mandible, closed reduction	\$290	
D7750	Malar and/or zygomatic arch, open reduction	\$220	
D7760	Malar and/or zygomatic arch, closed reduction	\$350	
D7770	Alveolus, open reduction stabilization of teeth	\$135	
D7771	Alveolus, closed reduction stabilization of teeth	\$160	
D7780	Facial bones, complicated reduction with fixation and multiple approaches	\$350	
D7810	Open reduction of dislocation	\$350	
D7820	Closed reduction of dislocation	\$80	
D7830	Manipulation under anesthesia	\$85	
D7840	Condylectomy	\$350	
D7850	Surgical discectomy, with/without implant	\$350	
D7852	Disc repair	\$350	
D7854	Synovectomy	\$350	
D7856	Myotomy	\$350	
D7858	Joint reconstruction	\$350	
D7860	Arthrotomy	\$350	
D7865	Arthroplasty	\$350	
D7870	Arthrocentesis	\$90	
D7871	Non-arthroscopic lysis and lavage	\$150	
D7872	Arthroscopy, diagnosis, with or without biopsy	\$350	
D7873	Arthroscopy: lavage and lysis of adhesions	\$350	
D7874	Arthroscopy: disc repositioning and stabilization	\$350	
D7875	Arthroscopy: synovectomy	\$350	
D7876	Arthroscopy: discectomy	\$350	
D7877	Arthroscopy: debridement	\$350	
D7880	Occlusal orthotic device, by report	\$120	
D7881	Occlusal orthotic device adjustment	\$30	
D7899	Unspecified TMD therapy, by report	\$350	
D7910	Suture of recent small wounds up to 5 cm	\$35	
D7911	Complicated suture, up to 5 cm	\$55	
D7912	Complicated suture, greater than 5 cm	\$130	
D7920	Skin graft (identify defect covered, location and type of graft)	\$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	\$80	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	\$350	
D7940	Osteoplasty, for orthognathic deformities	\$160	
D7941	Osteotomy, mandibular rami	\$350	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	\$350	
D7944	Osteotomy, segmented or subapical	\$275	
D7945	Osteotomy, body of mandible	\$350	
D7946	LeFort I (maxilla, total)	\$350	
D7947	LeFort I (maxilla, segmented)	\$350	
D7948	LeFort II or LeFort III, without bone graft	\$350	
D7949	LeFort II or LeFort III, with bone graft	\$350	
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	\$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$290	
D7952	Sinus augmentation via a vertical approach	\$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	\$200	
D7956	Guided tissue regeneration, edentulous area, resorbable barrier, per site	not covered	
D7957	Guided tissue regeneration, edentulous area, non-resorbable barrier, per site	not covered	
D7961	Buccal / labial frenectomy (frenulectomy)	\$120	1 (D7961) per arch per date of service
D7962	Lingual frenectomy (frenulectomy)	\$120	1 (D7962) per arch per date of service
D7963	Frenuloplasty	\$120	1 (D7963) per arch per date of service
D7970	Excision of hyperplastic tissue, per arch	\$175	1 (D7970) per arch per date of service
D7971	Excision of pericoronal gingiva	\$80	
D7972	Surgical reduction of fibrous tuberosity	\$100	1 (D7972) per arch per date of service
D7979	Non - surgical sialolithotomy	\$155	
D7980	Surgical sialolithotomy	\$155	
D7981	Excision of salivary gland, by report	\$120	
D7982	Sialodochoplasty	\$215	
D7983	Closure of salivary fistula	\$140	



LIBERTY Dental Plan of California, Inc.
Embedded Pediatric Dental - Silver AIAN

CDT Code	Description	Patient Responsibility	Limitation
Oral & Maxillofacial Services (continued)			
D7990	Emergency tracheotomy	\$350	
D7991	Coronoidectomy	\$345	
D7995	Synthetic graft, mandible or facial bones, by report	\$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	\$60	1 (D7997) per arch per date of service
D7999	Unspecified oral surgery procedure, by report	\$350	
Orthodontic Services			
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,000 per course of treatment, regardless	age 13 and over
D8091	Comprehensive orthodontic treatment with orthognathic surgery		
D8210	Removable appliance therapy		1 (D8210) per patient, age 6 through 12

D8220	Fixed appliance therapy	of plan year, as long as member remains enrolled in the plan	1 (D8220) per patient, age 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development		1 (D8660) every 3 months for a maximum of 6
D8670	Periodic orthodontic treatment visit		1 (D8670) per calendar quarter
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		1 (D8680) per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance, maxillary		1 of (D8696, D8697) per arch, per appliance
D8697	Repair of orthodontic appliance, mandibular		
D8698	Re-cement or re-bond fixed retainer, maxillary		1 of (D8698, D8699) per arch, per provider
D8699	Re-cement or re-bond fixed retainer, mandibular		
D8701	Repair of fixed retainer, includes reattachment, maxillary		
D8702	Repair of fixed retainer, includes reattachment, mandibular		
D8703	Replacement of lost or broken retainer, maxillary		1 of (D8703, D8704) per arch
D8704	Replacement of lost or broken retainer, mandibular		
D8999	Unspecified orthodontic procedure, by report		
Adjunctive General Services			
D9110	Palliative treatment of dental pain, per visit	\$30	1 (D9110) per date of service
D9120	Fixed partial denture sectioning	\$95	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$10	1 (D9210) per date of service
D9211	Regional block anesthesia	\$20	
D9212	Trigeminal division block anesthesia	\$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$15	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$45	
GUIDELINE:			
Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.			
D9222	Administration deep sedation/general anesthesia, first 15 minute increment or any portion thereof	\$45	
D9223	Administration deep sedation/general anesthesia, each subsequent 15 minute increment or any portion	\$45	
D9224	Administration of general anesthesia with advanced airway, first 15 minute increment, or any portion thereof	\$65	
D9225	Administration of general anesthesia with advanced airway, each subsequent 15 minute increment, or any portion thereof	\$65	
D9230	Administration of nitrous oxide	\$15	
D9239	Administration of moderate sedation, intravenous, first 15 minute increment or any portion thereof	\$60	
D9243	Administration of moderate sedation, intravenous, each subsequent 15 minute increment or any portion	\$60	
D9244	In-office administration of minimal sedation, single drug, enteral	\$30	
D9245	Administration of moderate sedation, enteral	\$65	
D9246	Administration of moderate sedation, non-intravenous parenteral, first 15 minute increment	\$65	
D9247	Administration of moderate sedation, non-intravenous parenteral, each subsequent 15 minute increment	\$65	
D9310	Consultation, other than requesting dentist	\$50	
D9311	Consultation with a medical health care professional	no charge	
D9410	House/extended care facility call	\$50	
D9420	Hospital or ambulatory surgical center call	\$135	
D9430	Office visit, observation, regular hours, no other services	\$20	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	\$45	1 (D9440) per date of service per provider
D9450	Case presentation, subsequent, detailed, extensive treatment planning	not covered	
D9610	Therapeutic parenteral drug, single administration	\$30	4 (D9610) per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	\$40	4 (D9612) per date of service
D9910	Application of desensitizing medicament	\$20	1 (D9910) per tooth every 12 months, for permanent teeth only
D9930	Treatment of complications, post surgical, unusual, by report	\$35	1 (D9930) per date of service per provider
D9942	Repair and/or reline of occlusal guard	not covered	
D9943	Occlusal guard adjustment	not covered	
D9944	Occlusal guard, hard appliance, full arch	not covered	
D9945	Occlusal guard, soft appliance, full arch	not covered	
D9946	Occlusal guard, hard appliance, partial arch	not covered	
D9950	Occlusion analysis, mounted case	\$120	1 (D9950) every 12 months, age 13 and over
D9951	Occlusal adjustment, limited	\$45	1 (D9951) per quad every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	\$210	1 (D9952) every 12 months, age 13 and over
D9995	Teledentistry, synchronous; real-time encounter	no charge	To the extent the dental plans can offer Teledentistry, it would be offered at no charge
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	no charge	
D9997	Dental case management, patients with special health care needs	no charge	
D9999	Unspecified adjunctive procedure, by report	no charge	

Pediatric Benefits – Children to the age of 19

Payment for services that are Optional or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual Out-of-Pocket Maximum is met.