

The "Select Dental" portion of the "MGM Resorts Health Plan (PPO)" is a non-PPO product. Any reference to "PPO" in the plan name or within this document does not apply to or describe the "Select Dental" portion of the benefit.

The Plan offers you a choice of where you receive your dental care. When you choose to receive your care from an In-Network LIBERTY Dental Plan contracted Select Dental provider, your costs will be limited by the amount identified in the first column (In-Network Member Copay). If you wish to receive care from an Out-of-Network provider, the second column (Out-of-Network Plan Pays) identifies the amount LIBERTY Dental Plan will pay for services and you will be responsible to pay any amount over the Plan Pays amount. You must meet an annual deductible amount before the Plan pays and an annual maximum amount payable by the Plan applies only when care is provided by an Out-of-Network provider.

<b>IN-NETWORK PROVIDER:</b> LIBERTY Dental Plan contracted Select Dental Provider (Nevada)	<b>OUT-OF-NETWORK PROVIDER:</b> Any licensed dentist
<b>IN-NETWORK ANNUAL DEDUCTIBLE:</b> None	<b>OUT-OF-NETWORK ANNUAL DEDUCTIBLE:</b> \$50 (Not waived for any service)
<b>IN-NETWORK ANNUAL PLAN PAY MAXIMUM:</b> Unlimited	<b>OUT-OF-NETWORK ANNUAL PLAN PAY MAXIMUM:</b> \$1,000

ADA CODE	DESCRIPTION OF SERVICES	IN-NETWORK MEMBER COPAY	OUT-OF-NETWORK PLAN PAYS
<b>DIAGNOSTIC</b>			
<b>Clinical Oral Evaluations</b>			
D0120	Periodic oral evaluation - established patient	\$0	\$25
D0140	Limited oral evaluation - problem focused	\$0	\$41
D0145	Oral evaluation for a patient under 3 years	\$0	\$41
D0150	Comprehensive oral evaluation - new or established patient	\$0	\$40
D0160	Detailed & extensive oral evaluation - problem focused, by report	\$0	\$25
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0	\$30
D0180	Comprehensive periodontal evaluation - new or established patient	\$0	\$40
<b>Radiographs/Diagnostic Imaging (Including Interpretation)</b>			
D0210	Intraoral - complete series (including bitewings)	\$0	\$70
D0220	Intraoral - periapical first film	\$0	\$14
D0230	Intraoral - periapical each additional film	\$0	\$10
D0240	Intraoral - occlusal film	\$0	\$17
D0250	Extraoral - first film	\$0	\$28
D0260	Extraoral - each additional film	\$0	\$27
D0270	Bitewings - single film	\$0	\$14
D0272	Bitewings - 2 films	\$0	\$18
D0273	Bitewings - 3 films	\$0	\$21
D0274	Bitewings - 4 films	\$0	\$28
D0277	Vertical bitewings - 7 to 8 films	\$0	\$35
D0330	Panoramic film	\$0	\$50
D0340	Cephalometric film	See Ortho	See Ortho
<b>Tests and Examinations</b>			
D0415	Collection of microorganisms for culture & sensitivity	\$0	\$28
D0425	Caries susceptibility tests	\$0	\$20
D0460	Pulp Vitality Tests	\$0	\$15
D0470	Diagnostic Casts	\$0	\$28
<b>Oral Pathology Laboratory</b>			
D0472	Accession of tissue, gross examination, preparation & transmission of written report	\$0	\$30
D0473	Accession of tissue, gross & microscopic examination, preparation & transmission of written report	\$0	\$61
D0474	Accession of tissue, gross & microscopic; assessment of surgical margins, preparation & transmission of report	\$0	\$73
<b>PREVENTIVE</b>			
<b>Dental Prophylaxis</b>			
D1110	Prophylaxis - adult	\$0	\$53
D1110	Prophylaxis - adult (third or more per 12 month period)	\$45	\$0
D1120	Prophylaxis - child	\$0	\$35
D1120	Prophylaxis - child (third or more per 12 month period)	\$35	\$0
<b>Topical Fluoride Treatment (Office Procedure)</b>			
D1203	Topical application of fluoride (prophylaxis not included) - child	\$0	\$18
D1203	Topical application of fluoride (prophylaxis not included) - child (third or more per 12 month period)	\$10	\$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	\$0	\$19
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	\$0	\$20

ADA CODE	DESCRIPTION OF SERVICES	IN-NETWORK MEMBER COPAY	OUT-OF-NETWORK PLAN PAYS
<b>Other Preventive Services</b>			
D1310	Nutritional counseling for control of dental disease	\$0	\$0
D1320	Tobacco counseling for the control & prevention of oral disease	\$0	\$0
D1330	Oral hygiene instructions	\$0	\$0
D1351	Sealant - per tooth	\$0	\$16
<b>Space Maintenance (Passive Appliances)</b>			
D1510	Space maintainer - fixed - unilateral	\$0	\$93
D1515	Space maintainer - fixed - bilateral	\$0	\$122
D1520	Space maintainer - removable - unilateral	\$0	\$115
D1525	Space maintainer - removable - bilateral	\$0	\$157
D1550	Recementation of space maintainer	\$0	\$20
D1555	Removal of fixed space maintainer	\$0	\$20
<b>RESTORATIVE</b>			
<b>Amalgam Restorations (Including Polishing)</b>			
D2140	Amalgam - 1 surface, primary or permanent	\$0	\$51
D2150	Amalgam - 2 surfaces, primary or permanent	\$0	\$65
D2160	Amalgam - 3 surfaces, primary or permanent	\$0	\$79
D2161	Amalgam - 4 or more surfaces, primary or permanent	\$0	\$96
<b>Resin-based Composite Restorations - Direct</b>			
D2330	Resin-based composite - 1 surface, anterior	\$0	\$60
D2331	Resin-based composite - 2 surfaces, anterior	\$0	\$77
D2332	Resin-based composite - 3 surfaces, anterior	\$0	\$85
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	\$0	\$98
D2390	Resin-based composite crown, anterior	\$0	\$0
D2391	Resin-based composite - 1 surface, posterior	\$30	\$25
D2392	Resin-based composite - 2 surfaces, posterior	\$34	\$41
D2393	Resin-based composite - 3 surfaces, posterior	\$40	\$50
D2394	Resin-based composite - 4 or more surfaces, posterior	\$59	\$46
<b>Inlay/Onlay Restorations</b>			
D2510	Inlay - metallic - 1 surface	\$0	\$223
D2520	Inlay - metallic - 2 surfaces	\$0	\$253
D2530	Inlay - metallic - 3 or more surfaces	\$0	\$292
D2542	Onlay - metallic - 2 surfaces	\$0	\$263
D2543	Onlay - metallic - 3 surfaces	\$0	\$277
D2544	Onlay - metallic - 4 or more surfaces	\$0	\$295
D2610	Inlay - porcelain/ceramic - 1 surface	\$0	\$237
D2620	Inlay - porcelain/ceramic - 2 surfaces	\$0	\$250
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	\$0	\$267
D2642	Onlay - porcelain/ceramic - 2 surfaces	\$0	\$287
D2643	Onlay - porcelain/ceramic - 3 surfaces	\$0	\$310
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	\$0	\$329
D2650	Inlay - resin-based composite - 1 surface	\$0	\$156
D2651	Inlay - resin-based composite - 2 surfaces	\$0	\$185
D2652	Inlay - resin-based composite - 3 or more surfaces	\$0	\$195
D2662	Onlay - resin-based composite - 2 surfaces	\$0	\$169
D2663	Onlay - resin-based composite - 3 surfaces	\$0	\$199
D2664	Onlay - resin-based composite - 4 or more surfaces	\$0	\$213
<i>Guideline: Porcelain/ceramic inlays and onlays and resin-based composite inlays and onlays are not covered benefits on molar teeth.</i>			
<b>Crowns - Single Restorations Only</b>			
D2710	Crown - resin-based composite (indirect)	\$0	\$255
D2712	Crown - 3/4 resin-based composite (indirect)	\$0	\$295
D2720	Crown - resin with high noble metal	\$0	\$405
D2721	Crown - resin with predominantly base metal	\$0	\$351
D2722	Crown - resin with noble metal	\$0	\$379
D2740	Crown - porcelain/ceramic substrate	\$0	\$427
D2750	Crown - porcelain fused to high noble metal	\$0	\$452
D2751	Crown - porcelain fused to predominantly base metal	\$0	\$428
D2752	Crown - porcelain fused to noble metal	\$0	\$436
D2780	Crown - 3/4 cast high noble metal	\$0	\$438
D2781	Crown - 3/4 cast predominantly base metal	\$0	\$418
D2782	Crown - 3/4 cast noble metal	\$0	\$410

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D2783	Crown - 3/4 porcelain/ceramic	\$0	\$428
D2790	Crown - full cast high noble metal	\$0	\$421
D2791	Crown - full cast predominantly base metal	\$0	\$404
D2792	Crown - full cast noble metal	\$0	\$410
D2794	Crown - titanium	\$0	\$430
D2799	Provisional crown	\$0	\$120
<b>Guideline:</b> Resin-based composite crowns, resin-based composite 3/4 crowns, porcelain/ceramic crowns, and porcelain/ceramic 3/4 crowns are not covered benefits on molar teeth. Restorations using "brand name" materials (e.g., Sunrise, Captek, Vitadur-N, Hi-Ceram, Optec HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) are considered to be optional upgraded treatment. The provider is required to explain the covered benefit, the difference in materials and cost differential to the member prior to providing a "brand name" restoration.			
<b>Other Restorative Services</b>			
D2910	Recement inlay, onlay, or partial coverage restoration	\$0	\$26
D2915	Recement cast or prefabricated post & core	\$0	\$26
D2920	Recement crown	\$0	\$27
D2930	Prefabricated stainless steel crown - primary tooth	\$0	\$72
D2931	Prefabricated stainless steel crown - permanent tooth	\$0	\$90
D2932	Prefabricated resin crown	\$0	\$80
D2933	Prefabricated stainless steel crown with resin window	\$0	\$98
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$0	\$80
D2940	Sedative filling	\$0	\$30
D2950	Core buildup, including any pins	\$0	\$78
D2951	Pin retention - per tooth, in addition to restoration	\$0	\$16
D2952	Post & core in addition to crown, indirectly fabricated	\$0	\$115
D2953	Each additional indirectly fabricated post - same tooth	\$0	\$40
D2954	Prefabricated post & Core in addition to crown	\$0	\$90
D2955	Post removal (not in conjunction with endodontic therapy)	\$0	\$50
D2957	Each additional prefabricated post -same tooth	\$0	\$40
D2960	Labial veneer (resin laminate) - chairside	\$200	\$110
D2961	Labial veneer (resin laminate) - laboratory	\$325	\$10
D2962	Labial veneer (porcelain laminate) - laboratory	\$500	\$50
D2970	Temporary crown (fractured tooth)	\$0	\$49
D2971	Additional procedures to construct new crown under existing partial denture framework	\$0	\$31
D2980	Crown repair, by report	\$0	\$0
<b>ENDODONTICS</b>			
<b>Pulp Capping</b>			
D3110	Pulp cap - direct	\$0	\$20
D3120	Pulp cap - indirect	\$0	\$18
<b>Pulpotomy</b>			
D3220	Therapeutic pulpotomy	\$0	\$48
D3221	Pulpal debridement, primary & permanent teeth	\$0	\$35
<b>Endodontic Therapy on Primary Teeth</b>			
D3230	Pulpal therapy (resorbable filling - anterior, primary tooth)	\$0	\$56
D3240	Pulpal therapy (resorbable filling - posterior, primary tooth)	\$0	\$60
<b>Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care</b>			
D3310	Root canal - anterior (excluding final restoration)	\$0	\$305
D3320	Root canal - bicuspid (excluding final restoration)	\$0	\$359
D3330	Root canal - molar (excluding final restoration)	\$0	\$505
D3331	Treatment of root canal obstruction; non-surgical access	\$0	\$70
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$0	\$196
D3333	Internal root repair of perforation defects	\$0	\$62
<b>Endodontic Retreatment</b>			
D3346	Retreatment of previous root canal therapy - anterior	\$0	\$305
D3347	Retreatment of previous root canal therapy - bicuspid	\$0	\$359
D3348	Retreatment of previous root canal therapy - molar	\$0	\$505
<b>Apexification/Recalcification Procedures</b>			
D3351	Apexification/recalcification - initial visit	\$0	\$80
D3352	Apexification/recalcification - interim medication replacement	\$0	\$55
D3353	Apexification/recalcification - final visit	\$0	\$105
<b>Apicoectomy/Periradicular Services</b>			
D3410	Apicoectomy/periradicular surgery - anterior	\$0	\$185
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$0	\$254

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D3425	Apicoectomy/periradicular surgery - molar (first root)	\$0	\$275
D3426	Apicoectomy/periradicular surgery (each additional root)	\$0	\$107
D3430	Retrograde filling - per root	\$0	\$78
D3450	Root Amputation - per root	\$0	\$159
<b>Other Endodontic Procedures</b>			
D3910	Surgical procedure for isolation of tooth with rubber dam	\$0	\$37
D3920	Hemisection (including any root removal), not including root canal therapy	\$0	\$124
D3950	Canal preparation & fitting of preformed dowel or post	\$0	\$50
<b>PERIODONTICS</b>			
<b>Surgical Services (Including Usual Postoperative Care)</b>			
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$0	\$115
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$0	\$55
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$0	\$165
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$0	\$100
D4245	Apically positioned flap	\$0	\$118
D4249	Clinical crown lengthening - hard tissue	\$0	\$189
D4260	Osseous surgery (including flap entry & closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$0	\$350
D4261	Osseous surgery (including flap entry & closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$0	\$210
D4263	Bone replacement graft - first site in quadrant	\$0	\$84
D4264	Bone replacement graft - each additional site in quadrant	\$0	\$45
D4270	Pedicle soft tissue graft procedure	\$0	\$244
D4271	Free soft tissue graft procedure (including donor site surgery)	\$0	\$250
D4274	Distal or proximal wedge procedure	\$0	\$90
<b>Non-Surgical Periodontal Service</b>			
D4320	Provisional splinting - intracoronal	\$0	\$90
D4321	Provisional splinting - extracoronal	\$0	\$79
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	\$0	\$69
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	\$0	\$38
<i>Guideline: No more than two (2) quadrants of periodontal scaling &amp; root planing per appointment/per day are allowable.</i>			
D4355	Full mouth debridement to enable comprehensive evaluation & diagnosis	\$0	\$35
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	\$0	\$0
<b>Other Periodontal Services</b>			
D4910	Periodontal maintenance	\$0	\$42
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$0	\$25
<b>PROSTHODONTICS (REMOVABLE)</b>			
<b>Complete Denture (Including Routine Post-delivery Care)</b>			
D5110	Complete denture - maxillary	\$0	\$501
D5120	Complete denture - mandibular	\$0	\$501
D5130	Immediate denture - maxillary	\$0	\$531
D5140	Immediate denture - mandibular	\$0	\$531
<b>Partial Dentures (Including Routine Post-delivery Care)</b>			
D5211	Maxillary partial denture - resin base	\$0	\$343
D5212	Mandibular partial denture - resin base	\$0	\$399
D5213	Maxillary partial denture - cast metal framework with resin denture bases	\$0	\$549
D5214	Mandibular partial denture - cast metal framework with resin denture bases	\$0	\$549
D5225	Maxillary partial denture - flexible base	\$0	\$442
D5226	Mandibular partial denture - flexible base	\$0	\$501
D5281	Removable unilateral partial denture - 1 piece cast metal	\$0	\$269
<b>Adjustments to Dentures</b>			
D5410	Adjust complete denture - maxillary	\$0	\$35
D5411	Adjust complete denture - mandibular	\$0	\$35
D5421	Adjust partial denture - maxillary	\$0	\$35
D5422	Adjust partial denture - mandibular	\$0	\$35
<b>Repairs to Complete Dentures</b>			
D5510	Repair broken complete denture base	\$0	\$55
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$0	\$41
<b>Repairs to Partial Dentures</b>			
D5610	Repair resin denture base	\$0	\$54
D5620	Repair cast framework	\$0	\$58
D5630	Repair or replace broken clasp	\$0	\$70
D5640	Replace broken teeth - per tooth	\$0	\$46

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D5650	Add tooth to existing partial denture	\$0	\$56
D5660	Add clasp to existing partial denture	\$0	\$67
D5670	Replace all teeth & acrylic on cast metal framework (maxillary)	\$0	\$182
D5671	Replace all teeth & acrylic on cast metal framework (mandibular)	\$0	\$182
<b>Denture Rebase Procedures</b>			
D5710	Rebase complete maxillary denture	\$0	\$184
D5711	Rebase complete mandibular denture	\$0	\$176
D5720	Rebase maxillary partial denture	\$0	\$173
D5721	Rebase mandibular partial denture	\$0	\$173
<b>Denture Reline Procedures</b>			
D5730	Reline complete maxillary denture (chairside)	\$0	\$104
D5731	Reline complete mandibular denture (chairside)	\$0	\$104
D5740	Reline maxillary partial denture (chairside)	\$0	\$95
D5741	Reline mandibular partial denture (chairside)	\$0	\$95
D5750	Reline complete maxillary denture (laboratory)	\$0	\$138
D5751	Reline complete mandibular denture (laboratory)	\$0	\$138
D5760	Reline maxillary partial denture (laboratory)	\$0	\$136
D5761	Reline mandibular partial denture (laboratory)	\$0	\$136
<b>Interim Prosthesis</b>			
D5810	Interim complete denture (maxillary)	\$0	\$202
D5811	Interim complete denture (mandibular)	\$0	\$217
D5820	Interim partial denture (maxillary)	\$0	\$169
D5821	Interim partial denture (mandibular)	\$0	\$180
<b>Other Removable Prosthetic Services</b>			
D5850	Tissue conditioning, maxillary	\$0	\$43
D5851	Tissue conditioning, mandibular	\$0	\$43
<b>IMPLANT SERVICES</b>			
<b>Surgical Services</b>			
D6010	Surgical placement of implant body: endosteal implant	\$2,000	\$534
<b>Implant Supported Prosthetics - Supporting Structures</b>			
D6056	Prefabricated abutment - includes placement	\$210	\$157
<b>Implant Supported Prosthetics - Single Crowns, Abutment Supported</b>			
D6058	Abutment supported porcelain/ceramic crown	\$1,110	\$511
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$1,096	\$504
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$1,035	\$476
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$1,056	\$486
D6062	Abutment supported cast metal crown (high noble metal)	\$1,003	\$484
D6063	Abutment supported cast metal crown (predominantly base metal)	\$861	\$416
D6064	Abutment supported cast metal crown (noble metal)	\$912	\$440
D6094	Abutment supported crown (titanium)	\$670	\$400
<b>Implant Supported Prosthetics - Single Crowns, Implant Supported</b>			
D6065	Implant supported porcelain/ceramic crown	\$1,040	\$502
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$1,013	\$489
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$984	\$475
<b>Implant Supported Prosthetics - Fixed Partial Denture, Abutment Supported</b>			
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$1,110	\$511
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$1,096	\$504
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$1,035	\$476
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$1,056	\$486
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$1,028	\$496
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$930	\$449
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$1,005	\$484
D6194	Abutment supported retainer crown for FPD (titanium)	\$670	\$412
<b>Implant Supported Prosthetics - Fixed Partial Denture, Implant Supported</b>			
D6075	Implant supported retainer for ceramic FPD	\$1,092	\$502
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	\$1,064	\$489
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	\$984	\$475
<b>Other Implant Services</b>			
D6092	Recement implant/abutment supported crown	\$45	\$39
D6093	Recement implant/abutment supported fixed partial denture	\$65	\$61
<b>PROSTHODONTICS (FIXED)</b>			

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<b>Fixed Partial Denture Pontics</b>			
D6205	Pontic - indirect resin based composite	\$0	\$292
D6210	Pontic - cast high noble metal	\$0	\$396
D6211	Pontic - cast predominantly base metal	\$0	\$377
D6212	Pontic - cast noble metal	\$0	\$370
D6214	Pontic - titanium	\$0	\$365
D6240	Pontic - porcelain fused to high noble metal	\$0	\$392
D6241	Pontic - porcelain fused to predominantly base metal	\$0	\$370
D6242	Pontic - porcelain fused to noble metal	\$0	\$385
D6245	Pontic - porcelain/ceramic	\$0	\$216
D6250	Pontic - resin with high noble metal	\$0	\$420
D6251	Pontic - resin with predominantly base metal	\$0	\$396
D6252	Pontic - resin with noble metal	\$0	\$405
D6253	Provisional pontic	\$0	\$150
<i>Guideline: Resin-based composite pontics and porcelain/ceramic pontics are not covered benefits to replace molar teeth. Restorations using "brand name" materials (e.g., Sunrise, Captek, Vitadur-IV, Hi-Ceram, Optec HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) are considered to be optional upgraded treatment. The provider is required to explain the covered benefit, the difference in materials and cost differential to the member prior to providing a "brand name" restoration.</i>			
<b>Fixed Partial Denture Retainers - Inlays/Onlays</b>			
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$0	\$216
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$0	\$241
D6600	Inlay - porcelain/ceramic, 2 surface	\$0	\$293
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	\$0	\$307
D6602	Inlay - cast high noble metal, 2 surfaces	\$0	\$313
D6603	Inlay - cast high noble metal, 3 or more surfaces	\$0	\$345
D6604	Inlay - cast predominantly base metal, 2 surfaces	\$0	\$307
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	\$0	\$325
D6606	Inlay - cast noble metal, 2 surfaces	\$0	\$302
D6607	Inlay - cast noble metal, 3 or more surfaces	\$0	\$335
D6624	Inlay - titanium	\$0	\$313
D6608	Onlay - porcelain/ceramic, 2 surfaces	\$0	\$318
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	\$0	\$333
D6610	Onlay - cast high noble metal, 2 surfaces*	\$0	\$338
D6611	Onlay - cast high noble metal, 3 or more surfaces	\$0	\$369
D6612	Onlay - cast predominantly base metal, 2 surfaces	\$0	\$336
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	\$0	\$351
D6614	Onlay - cast noble metal, 2 surfaces	\$0	\$329
D6615	Onlay - cast noble metal, 3 or more surfaces	\$0	\$342
D6634	Onlay - titanium	\$0	\$385
<i>Guideline: Porcelain/ceramic inlays and onlays and resin-based composite inlays and onlays are not covered benefits on molar teeth.</i>			
<b>Fixed Partial Denture Retainers - Crowns</b>			
D6710	Crown - indirect resin based composite	\$0	\$285
D6720	Crown - resin with high noble metal	\$0	\$442
D6721	Crown - resin with predominantly base metal	\$0	\$424
D6722	Crown - resin with noble metal	\$0	\$430
D6740	Crown - porcelain/ceramic	\$0	\$459
D6750	Crown - porcelain fused to high noble metal	\$0	\$415
D6751	Crown - porcelain fused to predominantly base metal	\$0	\$394
D6752	Crown - porcelain fused to noble metal	\$0	\$401
D6780	Crown - 3/4 cast high noble metal	\$0	\$430
D6781	Crown - 3/4 cast predominantly base metal	\$0	\$430
D6782	Crown - 3/4 cast noble metal	\$0	\$406
D6783	Crown - 3/4 porcelain/ceramic	\$0	\$439
D6790	Crown - full cast high noble metal	\$0	\$437
D6791	Crown - full cast predominantly base metal	\$0	\$420
D6792	Crown - full cast noble metal	\$0	\$432
D6793	Provisional retainer crown	\$0	\$159
D6794	Crown - titanium	\$0	\$452



ADA CODE	DESCRIPTION OF SERVICES	IN-NETWORK MEMBER COPAY	OUT-OF-NETWORK PLAN PAYS
<i>Guideline: Resin-based composite crowns, resin-based composite 3/4 crowns, porcelain/ceramic crowns, and porcelain/ceramic 3/4 crowns are not covered benefits on molar teeth. Restorations using "brand name" materials (e.g., Sunrise, Captek, Vitadur-N, Hi-Ceram, Optec HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) are considered to be optional upgraded treatment. The provider is required to explain the covered benefit, the difference in materials and cost differential to the member prior to providing a "brand name" restoration.</i>			
<b>Other Fixed Partial Denture Services</b>			
D6930	Recement fixed partial denture	\$0	\$41
D6940	Stress breaker	\$0	\$93
D6970	Post & core in addition to fixed partial denture retainer, indirectly fabricated	\$0	\$120
D6972	Prefabricated post & core in addition to fixed partial denture retainer	\$0	\$75
D6973	Core build up for retainer, including any pins	\$0	\$74
D6976	Each additional indirectly fabricated post - same tooth	\$0	\$48
D6977	Each additional prefabricated post - same tooth	\$0	\$46
D6980	Fixed partial denture repair, by report	\$0	\$0
<b>ORAL AND MAXILLOFACIAL SURGERY</b>			
<b>Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)</b>			
D7111	Extraction, coronal remnants - deciduous tooth	\$0	\$31
D7140	Extraction, erupted tooth or exposed root	\$0	\$41
<b>Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)</b>			
D7210	Surgical removal of erupted tooth	\$0	\$71
D7220	Removal of impacted tooth - soft tissue	\$0	\$89
D7230	Removal of impacted tooth - partially bony	\$0	\$125
D7240	Removal of impacted tooth - completely bony	\$0	\$175
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$0	\$195
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$0	\$69
<b>Other Surgical Procedures</b>			
D7261	Primary closure of a sinus perforation	\$0	\$146
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$0	\$109
D7280	Surgical access of an unerupted tooth	\$0	\$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$0	\$44
D7283	Placement of device to facilitate eruption of impacted tooth	\$0	\$29
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$0	\$95
D7286	Biopsy of oral tissue - soft	\$0	\$95
D7287	Exfoliative cytological sample collection	\$0	\$51
D7288	Brush biopsy - transepithelial sample collection	\$0	\$50
<b>Alveoplasty - Surgical Preparation of Ridge for Dentures</b>			
D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$0	\$68
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	\$0	\$41
D7320	Alveoplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$0	\$83
D7321	Alveoplasty not in conjunction with extractions 1 to 3 teeth or tooth spaces, per quadrant	\$0	\$50
D7340	Vestibuloplasty - ridge extension (second epithelialization)	\$0	\$175
D7350	Vestibuloplasty - ridge extension (w/ grafts/muscle reattachment/revision soft tissue attachment/management hypertrophied & hyperplastic tissue)	\$0	\$250
<b>Surgical Excision of Intra-osseous Lesions</b>			
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$0	\$191
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$0	\$299
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$0	\$191
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$0	\$307
<b>Excision of Bone Tissue</b>			
D7471	Removal of lateral exostosis (maxilla or mandible)	\$0	\$197
D7472	Removal of torus palatinus	\$0	\$235
D7473	Removal of torus mandibularis	\$0	\$221
D7485	Surgical reduction of osseous tuberosity	\$0	\$197
<b>Surgical Incision</b>			
D7510	Incision & drainage of abscess - intraoral soft tissue	\$0	\$65
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	\$0	\$65
D7520	Incision & drainage of abscess - extraoral soft tissue	\$0	\$155
D7521	Incision & drainage of abscess - extraoral soft tissue complicated	\$0	\$160
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$0	\$75
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$0	\$75
<b>Other Repair Procedures</b>			
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$0	\$45
D7963	Frenuloplasty	\$0	\$45

ADA CODE	DESCRIPTION OF SERVICES	IN-NETWORK MEMBER COPAY	OUT-OF-NETWORK PLAN PAYS
D7970	Excision of hyperplastic tissue - per arch	\$0	\$117
D7971	Excision of pericoronal gingiva	\$0	\$41
<b>ADJUNCTIVE GENERAL SERVICES</b>			
<b>Unclassified Treatment</b>			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$0	\$34
D9120	Fixed partial denture sectioning	\$0	\$25
<b>Anesthesia</b>			
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0	\$7
D9211	Regional block anesthesia	\$0	\$10
D9212	Trigeminal division block anesthesia	\$0	\$20
D9215	Local anesthesia	\$0	\$0
D9220	Deep sedation/general anesthesia - first 30 minutes	\$225	\$0
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$125	\$38
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide - first 15 minutes	\$35	\$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide - each additional 15 minutes	\$15	\$0
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$225	\$70
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$125	\$30
D9248	Non-intravenous conscious sedation	\$100	\$15
<i><b>Guideline:</b> Deep sedation/general anesthesia and intravenous conscious sedation/analgesia is a covered benefit when in conjunction with covered oral surgery and pedodontic procedures when dispensed in 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 and intravenous conscious sedation/analgesia.</i>			
<b>Professional Consultation</b>			
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0	\$35
<b>Professional Visits</b>			
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$0	\$25
D9440	Office visit - after regularly scheduled hours	\$0	\$60
D9450	Case presentation, detailed & extensive treatment planning	\$0	\$15
<b>Drugs</b>			
D9630	Other drugs and/or medicaments, by report	\$0	\$0
<b>Miscellaneous Services</b>			
D9910	Application of desensitizing medicament	\$0	\$10
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	\$0	\$16
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$0	\$60
D9940	Occlusal guard, by report	\$100	\$0
D9942	Repair and/or relines of occlusal guard	\$25	\$32
D9950	Occlusion analysis - mounted case	\$0	\$61
D9951	Occlusal adjustment - limited	\$0	\$58
D9952	Occlusal adjustment - complete	\$0	\$119
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	\$0	\$30
D9999	Broken Appointment (Less than 24 Hour Notice)	\$0	\$0
D9999	Office Visit - Per Visit	\$0	\$0

LIBERTY Dental Plan will arrange for you to receive services from a Contracted Dental Specialist if the necessary treatment is outside the scope of General Dentistry. Your General Dentist will initiate the referral process with LIBERTY Dental Plan. The proper referral process must be utilized for specialty services to be covered under your plan. X-rays for diagnostic purposes are benefits in the General Dentist's office only. Any specialty services received without prior authorization from LIBERTY Dental Plan will be covered under the Out-of-Network benefits.

**Classification of Metals (Source: ADA Council on Scientific Affairs)\***

The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content:

**High Noble:** Gold (Au), Palladium (Pd), and/or Platinum (Pt) equal to or more than 60% (with at least 40% gold).

**Titanium and titanium alloys:** Titanium (Ti) more than 85%.

**Noble:** Gold (Au), Palladium (Pd), and/or Platinum (Pt) equal to or more than 25%.

**Predominantly Base Metal:** Gold (Au), Palladium (Pd), and/or Platinum (Pt) less than 25%.

\*American Dental Association Code on Dental Procedures and Nomenclature



The "Select Dental" portion of the "MGM Resorts Health Plan (PPO)" is a non-PPO product. Any reference to "PPO" in the plan name or within this document does not apply to or describe the "Select Dental" portion of the benefit.

### ORTHODONTICS (Rider 0-200)

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

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

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

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

**Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider. Orthodontic treatment is not covered Out-of-Network.  
 Any procedure not listed as a covered benefit is available at the provider's usual and customary fee.**

ADA CODE	DESCRIPTION OF SERVICES	IN-NETWORK MEMBER CO-PAY
<b>Orthodontic Diagnostic Records</b>		
D0340	Cephalometric x-ray and tracings for orthodontic purposes	\$125
D0470	Diagnostic casts for orthodontic purposes	\$75
D9310	Initial consultation for orthodontic purposes	\$0
<b>Interceptive Orthodontic Treatment (18 Months of Usual and Customary Orthodontic Treatment)</b>		
D8050	Interceptive orthodontic treatment of the primary dentition	\$750
D8060	Interceptive orthodontic treatment of the transitional dentition	\$750
<b>Comprehensive Orthodontic Treatment (24 Months of Usual and Customary Orthodontic Treatment)</b>		
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,000
D8090	Comprehensive orthodontic treatment of the adult dentition	\$1,000
<b>Other Orthodontic Services</b>		
D8660	Pre-orthodontic treatment visit	\$0
D8670	Periodic orthodontic visits (as part of contract)	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$0
D8692	Replacement of lost or broken retainer	\$80
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	\$35
D8999	Broken appointment (less than 24 hour notice)	\$0

### ORTHODONTIC EXCLUSIONS

- 1 Coverage for stolen appliances.
- 2 Extractions for orthodontic purposes only.
- 3 Temporomandibular joint syndrome (TMJ) surgical orthodontics.
- 4 Myofunctional therapy.
- 5 Treatment of cleft palate.
- 6 Treatment of micrognathia.
- 7 Treatment of macroglossia.



The "Select Dental" portion of the "MGM Resorts Health Plan (PPO)" is a non-PPO product. Any reference to "PPO" in the plan name or within this document does not apply to or describe the "Select Dental" portion of the benefit.

**PLAN LIMITATIONS**

- 1 Prophylaxis is limited to one (1) treatment each six (6) month period (includes periodontal maintenance procedure following active therapy). Additional prophylaxis is available (In-Network only) at the listed Member Copy.
- 2 Oral evaluation is limited to two (2) in each twelve (12) month period. Only applies to D0120 (periodic oral evaluation), D0145 (oral evaluation under age 3), D0150 (comprehensive oral evaluation), and D0180 (comprehensive periodontal evaluation).
- 3 Oral hygiene instruction is limited to one (1) per twenty-four (24) month period.
- 4 Fluoride treatment is limited to one (1) treatment every six (6) month period. Additional fluoride treatments are available for children (In-Network only) at the listed Member Copy.
- 5 Inlays, onlays, crowns, full dentures, and fixed bridges may not be replaced within five (5) years from the latest placement.
- 6 Partial dentures are not to be replaced with five (5) years of the latest placement, unless due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- 7 Denture and partial denture relines are limited to one (1) per appliance during any twelve (12) consecutive months.
- 8 Covered charge for both a temporary and a permanent prosthesis will be limited to the charge for a permanent prosthesis only.
- 9 Charges for adjustment of a prosthesis will be limited to one (1) in a six (6) month period.
- 10 Periodontal treatments and periodontal surgery are limited to one (1) time per quadrant/site during any twenty-four (24) consecutive months.
- 11 Full mouth debridement is limited to one (1) treatment in any thirty-six (36) consecutive month period.
- 12 Osseous surgery is limited to one (1) treatment in any five (5) year period.
- 13 Crowns will be covered only if, in the opinion of LIBERTY Dental Plan's Dental Director, there is not enough retentive quality left in the tooth to hold a filling.
- 14 Bitewing x-rays are limited to not more than one (1) series in any six (6) month period.
- 15 Full mouth x-rays or panoramic film is limited to one (1) every thirty-six (36) consecutive months.
- 16 Sealants are benefits only for permanent first (1st) and second (2nd) molars with no decay and for dependent children only up to the age of fourteen (14). Sealants are limited to once per tooth in any thirty-six (36) consecutive month period.
- 17 Periodontal scaling and root planing limited to one (1) each quadrant/site in any twenty-four (24) consecutive month period.
- 18 Orthodontic coverage is only available from an In-Network LIBERTY Dental Plan contracted Orthodontist.
- 19 If LIBERTY Dental Plan determines that more than one (1) procedure could be performed to correct a dental condition, the covered benefit will be the least expensive of the procedures that would provide professionally acceptable results.

**PLAN EXCLUSIONS**

- 1 Any procedure not listed on the Benefit Schedule.
- 2 Dental services for aesthetics only and/or cosmetic dental care unless otherwise listed as a covered benefit.
- 3 General anesthesia, analgesia, intravenous/intramuscular and inhalation sedations, prescription drugs for anesthesia, and the services of an anesthesiologist unless otherwise listed as a covered benefit.
- 4 Dental conditions arising out of and due to a Member's employment or which the Member is entitled to Workers' Compensation benefits.
- 5 Hospital and medical facility charges of any kind.
- 6 Services of any kind provided in the home.
- 7 Ambulance services.
- 8 Durable medical equipment.
- 9 Mental health services.
- 10 Chemical dependency services.
- 11 Treatment started before the member was eligible, or after the member was no longer eligible.
- 12 Charges from a medical doctor, doctor of osteopathic medicine and/or other medical professional except for dental services otherwise covered herein.
- 13 Treatment of fractures or dislocations.
- 14 Replacement of lost or stolen dentures, partial dentures, or other appliances (e.g. crowns, fixed bridges, full and partial dentures).
- 15 Services which are normally reimbursed by a third party or liability insurance and/or under the medical portion of a group health plan.
- 16 Procedures, appliances, restorations or other treatment to correct congenital/developmental malformations or medically induced dental disorder, including but not limited to: myofunctional (e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to facial bones) unless otherwise covered as an orthodontic benefit.
- 17 Treatment and/or removal of: (a) malignancies; (b) cysts or benign tumors not within the scope of usual dental care.
- 18 Drugs/medications supplied or prescribed by a dentist.
- 19 Any treatment which, in the opinion of LIBERTY Dental Plan's Dental Director, is not necessary for the Member's dental health.
- 20 Replacement of an existing denture, partial denture, or fixed bridge which, in the opinion of LIBERTY Dental Plan's Dental Director, is satisfactory or can be made satisfactory.
- 21 Orthognathic surgery.
- 22 Implants or any prosthesis attached to or dependent upon an implant unless otherwise listed as a covered benefit.
- 23 Any experimental, investigational or exotic procedure not approved by the ADA Council on Dental Therapeutics.
- 24 Treatment to alter vertical dimension or to restore occlusion, unless dentures are involved.
- 25 Treatment or therapy for Temporomandibular Joint (TMJ) problems including, but not limited to, assessment beyond that customarily provided by a general dentist.
- 26 Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension or restoring occlusion.
- 27 Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three (3) years.
- 28 Treatment or service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction.
- 29 Expense or charge incurred by a Member confined to an institution of any kind.
- 30 Cases in which, in the reasonable professional judgment, LIBERTY Dental Plan's Dental Director, a satisfactory result cannot be obtained.
- 31 Replacement of a long-standing missing tooth/teeth in an otherwise stable dentition.
- 32 Orthodontic services unless otherwise listed as a covered benefit.
- 33 Care related to the bite, alignment of teeth, or bite correction unless otherwise listed as a covered benefit.
- 34 Charges for specialized techniques involving precision attachments, personalization or characterization of a prosthesis.





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