



**TEAMSTERS AND FOOD EMPLOYERS SECURITY TRUST FUND
PREFERRED PROVIDER PERIODONTIST SCHEDULE OF BENEFITS
PAYABLE ONLY TO SPECIALISTS IN PERIODONTICS**

ANY CURRENT DENTAL TERMINOLOGY CODE'S NOT LISTED ON THIS SCHEDULE OF BENEFITS IS NOT A COVERED BENEFIT.
ALL PERIODONTAL SERVICES MUST HAVE PRIOR APPROVAL - ANNUAL MAXIMUM - \$2,000.00
SOUTHERN CALIFORNIA REGION ONLY
EFFECTIVE DATE APRIL 1, 2019

Code	Description	Preferred Provider			Non-Preferred Provider	
		Schedule	Plan Pays	You Pay	Plan Pays	You Pay
D0180	comprehensive periodontal evaluation - new or established patient	\$97.00	\$97.00	\$0.00	\$41.00	Balance
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$395.00	\$355.50	\$39.50	\$160.00	Balance
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$200.00	\$180.00	\$20.00	\$80.00	Balance
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	\$495.00	\$445.50	\$49.50	\$202.00	Balance
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$245.00	\$220.50	\$24.50	\$101.00	Balance
D4260	osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$870.00	\$783.00	\$87.00	\$356.00	Balance
D4261	osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	\$400.00	\$360.00	\$40.00	\$178.00	Balance
D4263	bone replacement graft – retained natural tooth first site in quadrant	\$235.00	\$211.50	\$23.50	\$89.00	Balance
D4264	bone replacement graft – retained natural tooth - each additional site in quadrant	\$200.00	\$180.00	\$20.00	\$74.00	Balance
D4270	pedicle soft tissue graft procedure	\$485.00	\$436.50	\$48.50	\$208.00	Balance
D4277	free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	\$530.00	\$477.00	\$53.00	\$228.00	Balance
D4278	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth, implant, or edentulous tooth position in same graft site (used in conjunction with D4277)	\$530.00	\$477.00	\$53.00	\$228.00	Balance
D4341	periodontal scaling and root planing - four or more teeth per quadrant	\$165.00	\$148.50	\$16.50	\$65.00	Balance
D4342	periodontal scaling and root planing - one to three teeth per quadrant	\$80.00	\$72.00	\$8.00	\$33.00	Balance
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	\$180.00	\$162.00	\$18.00	\$74.00	Balance
D4910	periodontal maintenance	\$105.00	\$94.50	\$10.50	\$44.00	Balance
D9951	occlusal adjustment - limited	\$100.00	\$90.00	\$10.00	\$44.00	Balance
D9952	occlusal adjustment - complete	\$200.00	\$180.00	\$20.00	\$89.00	Balance

Out-of-Pocket costs are guaranteed at a Preferred Provider Dental Office. The cost to the Participant at Non-Preferred Provider Dental Offices are the differences between the Plan's Non-Preferred Provider Dentist's allowance and the Dentist's charge. Claims returned to the dentist marked with 8888 is for the procedures that do not receive an allowance (N/A), and 7777 is for by report (B/R) procedures.



**TEAMSTERS AND FOOD EMPLOYERS SECURITY TRUST FUND
PREFERRED PROVIDER PERIODONTIST SCHEDULE OF BENEFITS
PAYABLE ONLY TO SPECIALISTS IN PERIODONTICS**

ANY CURRENT DENTAL TERMINOLOGY CODE'S NOT LISTED ON THIS SCHEDULE OF BENEFITS IS NOT A COVERED BENEFIT.
ALL PERIODONTAL SERVICES MUST HAVE PRIOR APPROVAL - ANNUAL MAXIMUM - \$2,000.00
SOUTHERN CALIFORNIA REGION ONLY
EFFECTIVE DATE APRIL 1, 2019

DENTAL LIMITATIONS AND EXCLUSIONS FOR PERIODONTAL SPECIALISTS

1. All claims for periodontal scaling and root planing must be submitted to the Fund Office for approval prior to any services performed with diagnostic quality x-rays and charting (periodontal pocket markings) that support the need for periodontal scaling and root planing.
2. Periodontal surgical procedures will be covered only following initial non-surgical treatment involving periodontal scaling and root planing.
3. D0180 – Evaluation by a periodontist is covered only when the periodontal need from the receipt of claims form for patient is received from the general dentist.
4. D4210 and D4211 – Gingival flap procedures per quadrant. This is not covered if done in connection with Osseous Surgery, Gingivectomy, or Scaling and Root Planning.
5. D4240 and D4241 – Gingival Flap Procedures per Quadrant. This is not covered if done in connection with Osseous Surgery, Gingivectomy, or Scaling and Root Planning.
6. D4260 and D4261 – Ossous Surgery per Quadrant (limited to once per quadrant in a 60-month period). This includes but is not limited to the following:

Entry, Flap procedures, Extractions, Root amputations, Hemisection, Osetectomy including soft tissue grafts within the OPERATED AREA.
7. D4341 and D4342 – Periodontal scaling and root planing – PER QUADRANT. Maximum of two (2) quadrants are covered during any one visit. Not to exceed four (4) quadrants during 24-month period.
8. D4355 – Full Mouth Debridement – Entire mouth at same visit, only one in a 12 month period if needed. This is a preliminary procedure done only when Supra and/or subgingival calculus obstructs the ability to perform an initial oral evaluation. Note: Not allowable in conjunction with D0180 above.
9. D4910 – Periodontal Maintenance (Periodontal Prophylaxis). This is limited to Post-Surgival cases only. This is payable 3 to 6 months post-operatively and thereafter may be paid three (3) times during the next one and one-half years (18 months) or as designated by the Periodontal Consultant. Must be done under the direction of the Periodontist.
10. D9951 – Occlusal Adjustment – Limited. This does include equilibration of the entire dentition. This is a one-time allowance only.
11. D9952 – Occlusal Adjustment – Complete. This assumes mounted Casts on an Articulator, multiple visits and complete equilibration of the entire dentition.

Out-of-Pocket costs are guaranteed at a Preferred Provider Dental Office. The cost to the Participant at Non-Preferred Provider Dental Offices are the differences between the Plan's Non-Preferred Provider Dentist's allowance and the Dentist's charge. Claims returned to the dentist marked with 8888 is for the procedures that do not receive an allowance (N/A), and 7777 is for by report (B/R) procedures.