FIRST AMERITAS®
LIFE INSURANCE CORP. OF NEW YORK

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

SCHEDULE OF DENTAL PROCEDURES

The following is a complete list of all the dental procedures and Maximum Covered Expenses which are payable under this section. No benefits are payable for a procedure that is not listed.

PREVENTIVE PROCEDURES

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
VISITS AND EVALUATIONS.		
0120	Periodic oral evaluation.	$16.00
0150	Comprehensive oral evaluation.	25.00
	(0120 or 0150: Two evaluations will be allowed in a Benefit Period. These count toward this maximum allowance.)	
1120	Prophylaxis - under age 14.	24.00
1110	Prophylaxis - age 14 and over.	34.00
	(Prophylaxis (cleaning) will be allowed twice in a Benefit Period. An 1110, 1120, or 1201 counts toward this maximum allowance. Periodontal maintenance may be substituted for a cleaning (see requirements under Basic section). Benefits will not be available if performed on the same date as periodontal services)	
1201	Topical fluoride and prophylaxis.	37.00
1203	Topical fluoride (separate code) in conjunction with prophylaxis - child.	13.00
	(1201-1203: Coverage for fluoride treatment is limited to persons age 18 and under and to one treatment in a Benefit Period.)	
SPACE MAINTAINERS.		
1510	Fixed space maintainer, unilateral.	120.00
1515	Fixed space maintainer, bilateral.	197.00
1520	Removable space maintainer, unilateral.	188.00
1525	Removable space maintainer, bilateral.	229.00
	(1510-1525: Coverage is limited to space maintenance for unerupted teeth and following extraction of primary teeth. Allowance includes all adjustments within 6 months after installation.)	
1550	Recementation of space maintainer.	25.00
8210	Removable appliance to correct thumbsucking.	181.00
8220	Fixed appliance to correct thumbsucking.	181.00
Miscellaneous Preventive Procedures		
1351	Sealant - per tooth.	19.00
	(1351: Coverage is limited to treatment of the occlusal surface of permanent molar teeth once during a 3-year period for persons age 16 and under.)	

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BASIC PROCEDURES

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
VISITS AND EVALUATIONS.		
0140	Limited oral evaluation - problem focused	$21.00
0170	Re-evaluation - limited, problem focused (Established patient; not post-operative visit). (0140 and 0170: Coverage is limited to accidental injury only.)	21.00
9440	Office visit after hours (payment will be made on basis of services rendered or visit, whichever is greater).	37.00
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	31.00
9110	Palliative (emergency) treatment of dental pain - minor procedures, per visit. (Not a covered procedure if other procedures are reported except diagnostic radiographs.)	30.00
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. (4355: Coverage is limited to once during a 5-year period.*)	44.00
4910	Periodontal maintenance procedures (following active therapy). (4910: This procedure is available in place of an eligible routine prophylaxis (1110, 1120, or 1201) as listed above. Coverage is contingent upon evidence of a full mouth active periodontal therapy and limited to 2 allowances in a Benefit Period (a 1110, 1120, or 1201) counts toward this maximum allowance.)	46.00
9911	Application of desensitizing resin for cervical and/or root surface, per tooth.	44.00
PATHOLOGY.		
7285	Biopsy of oral tissue - hard (bone, tooth).	163.00
7286	Biopsy of oral tissue - soft (all others).	88.00
0472	Accession of tissue, gross examination, preparation and transmission of written report.	25.00
0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	50.00
0474	Accession of tissue, gross and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report.	50.00

*The frequency is measured forward from the last covered date of service for the procedure.

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
0501	Histopathologic examination. (0472-0501: Coverage is limited to one examination per biopsy/excision.)	$50.00
	RESTORATIVE DENTISTRY, excluding inlays, crowns and fixed partial dentures.	
	Amalgam Restorations.	
2110	One surface, primary.	32.00
2120	Two surfaces, primary.	40.00
2130	Three surfaces, primary.	50.00
2131	Four or more surfaces, primary.	59.00
2140	One surface, permanent.	36.00
2150	Two surfaces, permanent.	46.00
2160	Three surfaces, permanent.	55.00
2161	Four or more surfaces, permanent	66.00
	Resin Restorations.	
2330	Resin-based composite - one surface, anterior.	44.00
2331	Resin-based composite - two surfaces, anterior.	55.00
2332	Resin-based composite - three surfaces, anterior.	69.00
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	76.00
2336	Resin-based composite crown, anterior-primary.	93.00
2337	Resin-based composite crown, anterior-permanent. (2336-2337: Coverage is limited to persons age 18 and under.)	93.00 44.00
2385	Resin-based composite - one surface, posterior-permanent.	55.00
2386	Resin-based composite - two surfaces, posterior-permanent.	69.00
2387	Resin-based composite - three surfaces, posterior-permanent.	
2388	Resin-based composite - four or more surfaces, posterior-permanent. (2385-2388: Coverage is limited to permanent bicuspid teeth.)	76.00
	Other Restorative Services.	78.00
2930	Prefabricated stainless steel crown - primary tooth.	83.00
2931	Stainless steel crown - permanent tooth.	93.00
2932	Prefabricated resin crown. (2930-2932: Coverage is limited to persons age 18 and under.)	
2951	Pin retention, per tooth, in addition to restoration (3 pins per tooth maximum).	14.00
	Recementation.	29.00
2910	Inlay.	28.00
2920	Crown.	39.00
6930	Fixed Partial Denture.	
	Full and Partial Denture Repairs, Acrylic.	
	Repair of Complete Dentures.	46.00
5510	Repair broken base.	38.00
5520	Replace missing or broken teeth - each tooth.	

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
	Repair of Partial Dentures.	
5610	Repair resin denture base.	$45.00
5620	Repair cast framework.	53.00
5630	Repair or replace broken clasp.	56.00
5640	Replace broken teeth (per tooth).	40.00
	For relines more than six months after initial installation.	
5730	Reline complete maxillary denture (chairside).	84.00
5731	Reline complete mandibular denture (chairside).	83.00
5740	Reline maxillary partial denture (chairside).	75.00
5741	Reline mandibular partial denture (chairside).	76.00
5750	Reline complete maxillary denture (laboratory).	125.00
5751	Reline complete mandibular denture (laboratory).	122.00
5760	Reline maxillary partial denture (laboratory).	125.00
5761	Reline mandibular partial denture (laboratory).	125.00
	(5730-5761: Coverage for relines is limited to service dates more than 6 months after installation.)	
ORAL SURGERY.		
	Extractions. Includes local anesthesia, suturing, if needed, and routine postoperative care.	
7110	Extraction - single tooth.	40.00
7120	Extraction - each additional tooth.	37.00
7130	Root removal - exposed roots.	52.00
	Surgical Extractions. Includes local anesthesia, suturing, if needed, and routine postoperative care.	
7210	Surgical removal of erupted teeth.	77.00
9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	23.00
	Impacted Teeth. Includes local anesthesia, suturing, if needed, and routine postoperative care.	97.00
7220	Surgical removal of impacted tooth (soft tissue).	128.00
7230	Surgical removal of impacted tooth (partially bony).	150.00
7240	Surgical removal of impacted tooth (completely bony).	
7241	Removal of impacted tooth (completely bony, with unusual surgical complications), by report.	171.00 80.00
7250	Surgical removal of residual tooth roots (cutting procedure).	
	Alveolar or Gingival Reconstruction.	85.00
7320	Alveoplasty (without extractions) - per quadrant.	67.00
7310	Alveoplasty (with extractions) - per quadrant.	
7340	Vestibuloplasty - ridge extension (secondary epithelialization).	122.00
7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	304.00 110.00
7471	Removal of exostosis - per site. (7471: A maximum of 5 sites will be allowed.)	

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
	Cysts and Neoplasms.	
7510	Incision and drainage of abscess - intraoral soft tissue.	$54.00
7520	Incision and drainage of abscess - extraoral soft tissue.	62.00
7980	Sialolithotomy.	150.00
7983	Closure of salivary fistula.	48.00
7410	Radical excision - lesion diameter up to 1.25 cm.	121.00
7420	Radical excision - lesion diameter greater than 1.25 cm.	155.00
7430	Excision of benign tumor - lesion diameter up to 1.25 cm.	121.00
7431	Excision of benign tumor - lesion diameter greater than 1.25 cm.	155.00
7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	164.00
7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	120.00
7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	121.00
7451	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	155.00
7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	121.00
7461	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	155.00
7465	Destruction of lesion(s) by physical or chemical method, by report.	37.00
7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	115.00
7540	Removal of reaction-producing foreign bodies - musculoskeletal system.	137.00
7490	Radical resection of mandible with bone graft.	164.00
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	180.00
7260	Oral antral fistula closure.	190.00
7550	Sequestrectomy for osteomyelitis.	137.00
	Miscellaneous.	
7530	Removal of foreign body, skin, or subcutaneous areolar tissue.	50.00
7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	130.00
7910	Suture of recent small wounds - up to 5 cm.	24.00
7911	Complicated suture - up to 5 cm.	27.00
7912	Complicated suture - greater than 5 cm.	39.00
7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.	115.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	178.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption.	128.00

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
7480	Partial ostectomy (guttering or saucerization).	$164.00
7970	Excision of hyperplastic tissue - per arch.	100.00
ANESTHESIA.		
9220	General anesthesia - first 30 minutes (when administered by the dentist in the dentist's office).	115.00
9221	General anesthesia - each additional 15 minutes (when administered by the dentist in the dentist's office).	19.00
9241	Intravenous sedation/analgesia - first 30 minutes.	77.00
9242	Intravenous sedation/analgesia - each additional 15 minutes. (9220-9242: Coverage is not available without a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (9221 or 9242) will be considered.)	19.00

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BASIC PROCEDURES

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
RADIOGRAPHS.		
0220	Periapical radiograph - first film.	$8.00
0230	Additional periapical film, each.	6.00
0210	Intraoral - complete series (including bitewings).	43.00
0277	Vertical bitewings - 7 to 8 films.	28.00
0330	Panoramic film.	34.00
	(0210, 0277 or 0330: Only one of these procedures will be allowed in any three year period.*)	
0240	Intraoral, occlusal film.	11.00
0250	Extraoral, first film.	14.00
0260	Extraoral, each additional film.	11.00
0270	Bitewing, single film.	7.00
0272	Bitewing - two films.	12.00
0274	Bitewing - four films.	19.00
	(Bitewing films are limited to 2 allowances in a Benefit Period. An 0270, 0272, or 0274 counts toward this maximum allowance.)	

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MAJOR PROCEDURES

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
	RESTORATIVE. Inlays and crowns are covered only when necessitated by decay or traumatic injury.	
	Inlays.	
2336	Resin-based composite crown, anterior-primary.	$55.00
2337	Resin-based composite crown, anterior-permanent.	55.00
2510	Inlay - metallic - one surface.	145.00
2520	Inlay - metallic - two surfaces.	173.00
2530	Inlay - metallic - three or more surfaces.	186.00
2542	Onlay - metallic - two surfaces.	188.00
2543	Onlay - metallic - three surfaces.	210.00
2544	Onlay - metallic - four or more surfaces.	218.00
2610	Inlay porcelain/ceramic - one surface.	160.00
2620	Inlay porcelain/ceramic - two surfaces.	174.00
2630	Inlay - porcelain/ceramic - three or more surfaces.	190.00
2642	Onlay - porcelain/ceramic - two surfaces.	188.00
2643	Onlay - porcelain/ceramic - three surfaces.	210.00
2644	Onlay - porcelain/ceramic - four or more surfaces.	217.00
2650	Inlay - resin-based composite composite/resin - one surface.	166.00
2651	Inlay - resin-based composite composite/resin - two surfaces.	164.00
2652	Inlay - resin-based composite composite/resin - three surfaces.	169.00
2662	Onlay - resin-based composite composite/resin - two surfaces.	176.00
2663	Onlay - resin-based composite composite/resin - three surfaces.	181.00
2664	Onlay - resin-based composite composite/resin - four or more surfaces.	193.00
	Crowns.	82.00
2710	Resin.	210.00
2720	Resin with high noble metal.	160.00
2721	Resin with predominantly base metal.	196.00
2722	Resin with noble metal.	226.00
2740	Porcelain/ceramic substrate.	220.00
2750	Porcelain fused to high noble metal.	189.00
2751	Porcelain fused to predominantly base metal.	202.00
2752	Porcelain fused to noble metal.	209.00
2780	Crown - 3/4 cast high noble metal.	182.00
2781	Crown - 3/4 cast predominately base metal.	190.00
2782	Crown - 3/4 cast noble metal.	226.00
2783	Crown - 3/4 porcelain/ceramic.	209.00
2790	Full cast high noble metal.	182.00
2791	Full cast predominantly base metal.	190.00
2792	Full cast noble metal.	

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
2930	Prefabricated stainless steel crown - primary tooth.	$46.00
2931	Prefabricated stainless steel crown - permanent tooth.	49.00
2932	Prefabricated resin crown.	55.00
	(2336-2932: These procedures are limited to necessary placement resulting from decay or traumatic injury. Inlays will be reimbursed at the alternate allowance of an amalgam or composite restoration.)	
2950	Core build-up, including any pins.	45.00
2952	Cast post and core, in addition to crown.	72.00
2954	Prefabricated post and core, in addition to crown.	60.00
4249	Clinical crown lengthening - hard tissue.	130.00
PROSTHODONTICS - FIXED.		
	Fixed Partial Denture Abutments	
6519	Inlay/onlay - porcelain/ceramic.	213.00
6520	Inlay - metallic - two surfaces.	142.00
6530	Inlay - metallic - three or more surfaces.	249.00
6543	Onlay - metallic - three surfaces.	213.00
6544	Onlay - metallic - four or more surfaces.	201.00
6545	Retainer - cast metal for resin bonded fixed prosthesis.	71.00
6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	71.00
6720	Crown - resin with high noble metal.	213.00
6721	Crown - resin with predominantly base metal.	110.00
6722	Crown - resin with noble metal.	178.00
6740	Crown - porcelain/ceramic.	195.00
6750	Crown - porcelain fused to high noble metal.	231.00
6751	Crown - porcelain fused to predominantly base metal.	213.00
6752	Crown - porcelain fused to noble metal.	195.00
6780	Crown - 3/4 cast high noble metal.	231.00
6781	Crown - 3/4 cast predominately base metal.	213.00
6782	Crown - 3/4 cast noble metal.	195.00
6783	Crown - 3/4 porcelain/ceramic.	195.00
6790	Crown - full cast high noble metal.	213.00
6791	Crown - full cast predominantly base metal.	213.00
6792	Crown - full cast noble metal.	195.00
6940	Stress breaker.	59.00
6970	Cast post and core in addition to fixed partial denture retainer.	64.00
6971	Cast post as part of fixed partial denture retainer.	64.00
6972	Prefabricated post and core in addition to fixed partial denture retainer.	64.00
	Implant Supported	
6058	Abutment supported porcelain/ceramic crown.	195.00
6059	Abutment supported porcelain fused to metal crown (high noble metal).	213.00

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$213.00
6061	Abutment supported porcelain fused to metal crown (noble metal).	195.00
6062	Abutment supported cast metal crown (high noble metal).	213.00
6063	Abutment supported cast metal crown (predominantly base metal).	213.00 231.00
6064	Abutment supported cast metal crown (noble metal).	195.00
6065	Implant supported porcelain/ceramic crown.	
6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	213.00
6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	213.00 195.00
6068	Abutment supported retainer for porcelain /ceramic FPD.	
6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	213.00
6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal).	213.00
6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	195.00
6072	Abutment supported retainer for cast metal FPD (high noble metal).	213.00
6073	Abutment supported retainer for cast metal FPD (predominately base metal).	213.00 231.00
6074	Abutment supported retainer for cast metal FPD (noble metal).	195.00
6075	Implant supported retainer for ceramic FPD.	
6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	213.00
6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal).	213.00
	(6058-6077: Although implants are not a covered benefit, these procedures can qualify for benefits. Coverage is subject to the replacement and extraction provisions as defined under the limitations section of this contract.)	
	Pontics.	213.00
6210	Cast high noble metal.	213.00
6211	Cast predominantly base metal.	231.00
6212	Cast noble metal.	213.00
6240	Porcelain fused to high noble metal.	213.00
6241	Porcelain fused to predominantly base metal.	195.00
6242	Porcelain fused to noble metal.	195.00
6245	Porcelain/ceramic.	213.00
6250	Resin with high noble metal.	195.00
6251	Resin with predominantly base metal.	231.00
6252	Resin with noble metal.	
	Repairs, crowns and fixed partial dentures.	41.00
6980	Fixed partial denture repair, by report.	37.00
2980	Crown repair, by report.	

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
PROSTHODONTICS - REMOVABLE		
	Partials and Dentures (Fees for both partials and complete dentures and relining include adjustments within six months after installation Precision attachments, overdentures, specialized techniques and characterizations are considered optional and the additional expense for these shall be borne by the patient. All partials include conventional clasps, rests and teeth.)	
5110	Complete denture - maxillary.	$234.00
5120	Complete denture - mandibular.	227.00
5130	Immediate denture - maxillary.	254.00
5140	Immediate denture - mandibular.	245.00
5211	Maxillary partial denture - resin base.	168.00
5212	Mandibular partial denture - resin base.	195.00
5213	Maxillary partial denture - cast metal framework with resin denture bases.	271.00
5214	Mandibular partial denture - cast metal framework with resin denture bases.	271.00
5281	Removable unilateral partial denture - one piece cast metal.	145.00
5820	Interim partial denture (maxillary).	91.00
5821	Interim partial denture (mandibular).	96.00
5810	Interim complete denture (maxillary).	103.00
5811	Interim complete denture (mandibular).	109.00
5410	Adjust complete denture - maxillary.	13.00
5411	Adjust complete denture - mandibular.	12.00
5421	Adjust partial denture - maxillary.	14.00
5422	Adjust partial denture - mandibular. (5410-5422: Coverage is limited to an adjustment with a date of service more than 6 months after installation.)	13.00
5850	Tissue conditioning, maxillary.	24.00
5851	Tissue conditioning, mandibular.	26.00
5710	Rebase - complete maxillary denture	85.00
5711	Rebase - complete mandibular denture.	90.00
5720	Rebase - maxillary partial denture.	81.00
5721	Rebase - mandibular partial denture.	86.00
	Adding teeth to partial denture to replace extracted natural teeth.	
5650	Add tooth to existing partial denture.	30.00
5660	Add clasp to existing partial denture.	35.00

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PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
ENDODONTICS.		
3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$29.00
3221	Gross pulpal debridement, primary and permanent teeth.	29.00
3230	Pulpal therapy (resorbable filling) - anterior, primary tooth.	38.00
3240	Pulpal therapy (resorbable filling) - posterior, primary tooth.	33.00
3310	Root canal, anterior (excluding final restoration).	131.00
3320	Root canal, bicuspid (excluding final restoration).	155.00
3330	Root canal, molar (excluding final restoration).	203.00
3332	Incomplete endodontic therapy; inoperable or fractured tooth.	15.00
3333	Internal root repair of perforation defects. (3310-3333: Coverage is limited to permanent teeth. Allowance includes intraoperative films and cultures but excludes final restoration.)	47.00
3346	Retreatment of previous root canal therapy - anterior.	164.00
3347	Retreatment of previous root canal therapy - bicuspid.	189.00
3348	Retreatment of previous root canal therapy - molar. (3346-3348: Coverage is limited to permanent teeth and to service dates more than 12 months after root canal therapy or a previous retreatment. Allowance includes intraoperative films and cultures but excludes final restoration.)	234.00
3351	Apexification/recalcification - initial visit.	47.00
3352	Apexification/recalcification - interim medication replacement.	32.00
3353	Apexification/recalcification - final visit.	93.00
3410	Apicoectomy/periradicular surgery - anterior.	135.00
3421	Apicoectomy/periradicular surgery - bicuspid (first root).	156.00
3425	Apicoectomy/periradicular surgery - molar (first root).	169.00
3426	Apicoectomy/periradicular surgery - each additional root.	60.00
3430	Retrograde filling - per root.	37.00
3450	Root amputation - per root.	88.00
3920	Hemisection (including any root removal), not including root canal therapy.	74.00
PERIODONTICS.		
	Surgical Procedures (including postoperative visits).	
4220	Gingival curettage, surgical, per quadrant, by report.	42.00
4240	Gingival flap procedure, including root planing, per quadrant.	118.00
4210	Gingivectomy or gingivoplasty, per quadrant.	86.00
4211	Gingivectomy or gingivoplasty, per tooth.	29.00

MAJOR PROCEDURES (continued)

PROC. NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
4260	Osseous surgery (including flap entry and closure) - per quadrant.	$216.00
4263	Bone replacement graft - first site in quadrant.	70.00
4264	Bone replacement graft - each additional site in quadrant. (4210-4264: Each procedure is eligible for consideration once in a 3-year period.*)	53.00
4270	Pedicle soft tissue graft procedure.	159.00
4271	Free soft tissue graft procedure (including donor site surgery) reported with periodontal procedures.	168.00
4273	Subepithelial connective tissue graft procedure (including donor site surgery) reported with periodontal procedures. (4270-4273: A maximum of two sites per quadrant will be considered in a 3-year period.*)	196.00
4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	94.00
	Non-surgical Periodontal Procedures.	
4341	Periodontal scaling and root planing, limited (per quadrant). (4341: Each quadrant is eligible for consideration once in a 2-year period.*)	44.00
4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth. (4381: A scaling and planing (4341) must be performed within 6 weeks prior to treatment. A maximum of 2 sites per quadrant will be considered and the frequency is limited to once in any 2-year period.)	32.00
9951	Occlusal adjustment, limited.	17.00
9952	Occlusal adjustment, complete. (9951-9952: Coverage is limited to adjustment performed in conjunction with treatment of periodontal disease.)	86.00

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