

# Greenberg

## Head Start Preferred Plan

For Head Start Students & Immediate Family

### Head Start Visit

**\$59**

- Necessary X-Rays
- Cleaning
- Flouride Treatment
- Completed Head Start Form

#### Pediatrics

<b>Silver Filling - 1 Surface</b> .....	<b>\$50</b>
<b>Silver Filling - 2 Surface</b> .....	<b>\$70</b>
<b>Silver Filling - 3 Surface</b> .....	<b>\$85</b>
<b>Pulpotomy (Baby Root Canal)</b> .....	<b>\$75</b>
<b>Stainless Steel Cap (Baby Tooth)</b> .....	<b>\$120</b>
<b>Extraction</b> .....	<b>\$85</b>

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Appointments - Diagnostic</b>				
D0120	Periodic oral exam	\$15	52	71%
D0140	Limited oral exam	\$15	79	81%
D0150	Comprehensive oral exam	\$25	91	73%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Radiographs - X-rays</b>				
D0210	Intraoral - complete series (incl bitewings)	\$60	134	55%
D0220	Intraoral - periapical	\$12	30	60%
D0272	Bitewing - two films	\$20	47	57%
D0274	Bitewing - four films	\$25	68	63%
D0330	Panoramic film	\$50	114	56%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Preventive</b>				
D1110	Prophylaxis (cleaning) - Adult	\$40	94	57%
D1120	Prophylaxis - child	\$30	69	57%
D1203	Topical Application of fluoride - child	\$14	39	64%
D1351	Sealant - per tooth	\$19	57	66%
D1510	Space Maintainer - fixed, unilateral	\$175	327	46%
D1515	Space Maintainer - fixed, bilateral	\$225	446	50%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Restorative Fillings</b>				
D2140	Amalgam - Silver one surface, child or adult	\$50	148	66%
D2150	Amalgam - Silver two surface, child or adult	\$70	186	62%
D2160	Amalgam - Silver three surface, child or adult	\$85	224	62%
D2330	Resin - White - anterior one surface	\$65	167	61%
D2331	Resin - White - anterior two surface	\$80	208	62%
D2332	Resin - White - anterior three surface	\$100	261	62%
D2335	Resin - White - anterior 4+ surfaces w/ incisal angle	\$115	327	65%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Orthodontics - Braces **Payment Plans Available**</b>				
D8660	Orthodontic Exam	FREE	400	100%
D8080	Comprehensive Ortho Treatment-Child (24 months)	\$3,895	5230	26%
D8090	Comprehensive Ortho Treatment-Adult (24 months)	\$4,195	5300	21%
D8999	Ceramic (Clear) Braces - Upper Teeth	\$250	500	50%
	Ceramic (Clear) Braces - Upper and Lower Teeth	\$400	800	50%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Adjunctive - General Services</b>				
D9972	Bleaching - both upper and lower arches	\$300	730	59%

Specialty services may not be available in all areas.

Rates are subject to periodic change without prior notification.

This fee schedule applies to procedures performed by a General/Pediatric Dentist and Orthodontist only.

Non-listed procedures are provided to all members at 25% off the dentists' usual & customary fee.

Procedures performed by other Dental Specialists are provided to all members at 25% off the dentists' usual and customary (prevailing) fee.

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Endodontics - Root Canals</b>				
D3110	Pulp cap - direct (excluding final restoration)	\$30	86	65%
D3120	Pulp cap - indirect (excluding final restoration)	\$30	89	66%
D3220	Pulpotomy (excluding final restoration)	\$75	206	64%
D3310	Root Canal - Front tooth (Anterior)	\$325	801	59%
D3320	Root Canal - Middle tooth (bicuspid)	\$400	872	54%
D3330	Root Canal - Back Tooth (Molar)	\$500	1121	55%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Periodontics - Gum Treatment</b>				
D4210	Gingivectomy or gingivoplasty - per quadrant	\$400	669	40%
D4211	Gingivectomy or gingivoplasty - per tooth	\$150	323	54%
D4260	Osseous surgery - per quadrant	\$800	1114	28%
D4261	Osseous graft - per tooth	\$400	942	58%
D4341	Periodontal scaling & root planing - per quadrant	\$80	263	70%
D4355	Full mouth debridement	\$60	190	68%
D4910	Periodontal maintenance prophylaxis	\$60	146	59%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Prosthodontics - Dentures &amp; Partials</b>				
D5110	Upper denture	\$800	1785	55%
D5120	Lower denture	\$800	1788	55%
D5211	Upper partial - resin (plastic) base	\$625	1413	56%
D5212	Lower partial - resin (plastic) base	\$625	1413	56%
D5213	Upper partial - cast metal base w/resin saddles	\$800	1862	57%
D5214	Lower partial - cast metal base w/resin saddles	\$800	1862	57%
D5410	Denture adjustment (upper)	\$40	94	57%
D5411	Denture adjustment (lower)	\$40	93	57%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Prosthodontics - Fixed - Bridge Pontics</b>				
D-6240	Pontic - porcelain fused to precious (gold) metal	\$600	1155	48%
D-6241	Pontic - porcelain fused to base metal	\$495	1064	53%
D-6750	Crown - porcelain fused to precious (gold) metal	\$600	1165	48%
D-6751	Crown - porcelain fused to base metal	\$495	1066	54%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Oral Surgery - Extractions</b>				
D7140	Extraction, erupted tooth or exposed root	\$85	183	54%
D7210	Surgical extraction - erupted tooth	\$125	288	57%
D7220	Removal of impacted tooth - soft tissue	\$200	327	39%
D7230	Removal of impacted tooth - partial bony	\$250	411	39%
D7240	Removal of impacted tooth - complete bony	\$300	511	41%
D7510	Incision and drainage of abscess - intraoral	\$150	248	40%
D7971	Excision of pericoronal gingiva	\$100	275	64%

CDT Code	Description	Member Co-Pay	Prevailing Fee	% Saving
<b>Crown - Single Restoration</b>				
D2740	Crown - porcelain/ceramic substrate (metal free)	\$600	1190	50%
D2750	Crown - porcelain fused precious (Gold) metal	\$600	1140	47%
D2751	Crown - porcelain fused to base metal	\$495	1091	55%
D2920	Re-cement crown	\$40	114	65%
D2930	Stainless steel, primary	\$120	282	57%
D2931	Stainless steel, permanent	\$130	338	62%
D2940	Sedative filling	\$40	128	69%
D2950	Core buildup	\$120	283	58%
D2954	Prefabricated post and core in addition to crown	\$150	347	57%



**Orange County Family Services Department  
Head Start Division  
Dental Services Verification**



Child's Name \_\_\_\_\_ D.O.B: \_\_\_\_\_ Center: \_\_\_\_\_

**Routine Examination Prophylaxis & Fluoride**

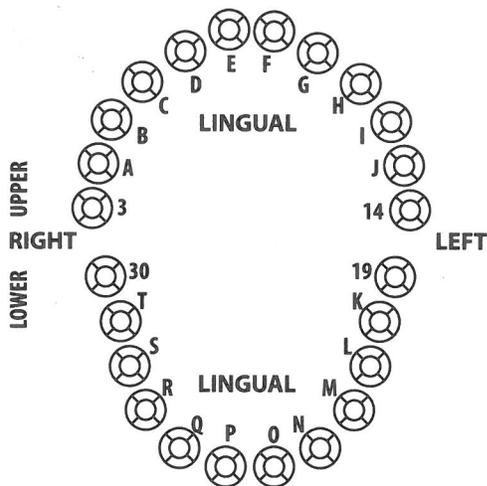
Routine examination performed on: \_\_\_\_\_

Prophylaxis performed on: \_\_\_\_\_

Fluoride applied on: \_\_\_\_\_

Is treatment needed based on examination?

Yes  No



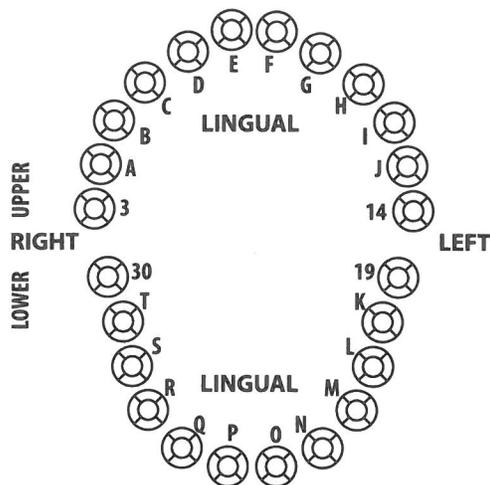
Please indicate affected teeth and treatment needed:  
\_\_\_\_\_  
\_\_\_\_\_

Referred to Pediatric Dental Specialist?  
Yes  No

Signature of Dentist: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date: \_\_\_\_\_

**Follow - Up Dental Treatment**

Date: \_\_\_\_\_



Treatment performed during this visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All treatment completed? Yes  No   
Return appointment scheduled? Yes  No   
Date of appointment: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date: \_\_\_\_\_

As Parent or Legal Guardian of \_\_\_\_\_, I hereby give my permission for the above information to be released to the Orange County Head Start Program.

Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Original: Head Start Center                      Yellow: Main Office                      Pink: Parent**