INSURANCE TRUST FUND LOCAL 1034
Plan Description and Fee Schedule

ELIGIBLE: *All members covered under the Insurance Trust Fund Local 1034 are eligible for dental benefits.*

DEPENDENT COVERAGE: *Spouse, and unmarried children (unmarried dependent children are covered through December 31 of the year in which they reach age 23).*

PLAN MAXIMUM: *There is no annual maximum*

ORTHODONTICS: *$1,500 lifetime maximum for each covered individual.*

DEDUCTIBLE: *There is no deductible*.

LIMITATIONS:

Examination - *two in a calendar year*
Full mouth or Panoramic x-ray - *one in a thirty-six month period*
Prophylaxis - *two in a calendar year*
Replacement of crowns, bridges and dentures - *not more than once in 5 years*
Palliative treatment - *no other treatment that same visit*
Root scaling, curettage, bite correction, any combination - *maximum $120. in a calendar year*
Sealant- *permanent posterior teeth to age 19, maximum one application per lifetime*
Topical fluoride treatment - *to age 19, one application per year*
Specialist Consultation - *maximum one in a calendar year*
Orthodontics - *active treatment, maximum 24 months*
General Anesthesia/IV Sedation- *First 30 minutes only*

PLAN EXCLUSIONS:

Certain procedures such as Crown Lenthening and Crown Buildup are deemed to be inclusive in the permanent restoration and are not chargeable to the patient
When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

PREAUTHORIZATION REQUIREMENTS:

Pre-op periapical x-rays required for crowns, veneers, inlays & extractions
Periodontal pocket charting and x-rays are required for periodontal treatment
Pre-op periapical x-rays of the entire arch required for fixed and removable bridges

PERMISSIBLE CHARGES:

Covered and reimbursable services: *no surcharge permitted*
Covered but not reimbursable services: *scheduled allowance*
Non-covered service: procedures not listed as reimbursable benefits by the Fund: *your usual charge for that service*

COORDINATION OF BENEFITS: *If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans up to the allowable usual and customary charge. The total may not exceed your usual and customary charge.*

CLAIM SUBMISSION: *Universal and computer generated claim forms are accepted. Original signature required. Pre-determination requests and payment claims are sent to:*

Self-Insured Dental Services
71 South Central Avenue, Dept. 74
Valley Stream, New York 11582-0607
(516)396-5500/(718)204-7172

THERE IS NO FEE FOR MEMBERSHIP Eff 06/98

Insurance Trust Fund Local 1034
Allowable Charges

	Plan Pays
I-DIAGNOSTIC & PREVENTIVE	
ORAL EXAM	15.00
FULL MOUTH SERIES OR PANORAMIC FILM	25.00
PERIAPICAL X-RAY (EACH FILM)	3.00
BITEWING-(EACH FILM)	3.00
OCCLUSAL FILM	15.00
CEPHALOMETRIC FILM	34.00
POSTERIOR-ANTERIOR,LATERAL FILM	25.00
EXTRAORAL or TMJ FILM	25.00
PALLIATIVE-EMERGENCY TRT	30.00
CONSULTATION BY SPECIALIST	50.00
II-PREVENTIVE	
PROPHYLAXIS-ADULT or CHILD	22.00
FLUORIDE EXCL. PROPHY	10.00
SEALANT-PER TOOTH	15.00
SPACE MAINTAINER	100.00
RECEMENT SPACE MAINTAINER	30.00
III-RESTORATIVE	
AMALGAM - 1 SRF PRIMARY	25.00
AMALGAM - 2 SRF PRIMARY	35.00
AMALGAM - 3 OR MORE SURFACE	45.00
AMALGAM - 1 SRF PERMANENT	25.00
AMALGAM - 2 SRF PERMANENT	35.00
AMALGAM - 3 OR MORE SURFACES	45.00
RESIN-1 SURFACE, ANTERIOR	45.00
RESIN-2 SURFACE, ANTERIOR	50.00
RESIN-3 OR MORE SURFACES	55.00
RESIN-1 SURFACE, POSTERIOR	45.00
RESIN-2 SURFACE POSTERIOR	50.00
RESIN-3 OR MORE SURFACES	55.00
METALLIC INLAY-1 SRF	150.00
METALLIC INLAY-2 SRF	190.00
METALLIC INLAY-3 SRF	230.00
ONLAY-METALLIC	70.00
PORCELAIN INLAY-1 SRF	150.00
PORCELAIN INLAY-2 SRF	180.00
PORCELAIN INLAY-3 SRF	210.00
PORCELAIN JACKET	325.00
ACRYLIC JACKET	250.00
CROWN-RESIN WITH METAL	280.00
CROWN-PORCELAIN WITH METAL	375.00
CROWN-FULL OR 3/4 CAST	300.00
RECEMENT CROWN OR INLAY	30.00
PREFAB SS CROWN-PRIMARY	100.00
PIN RETENTION-PER TOOTH	15.00
CAST POST AND CORE	125.00
PREFAB POST AND CORE	75.00
LABIAL VENEER, LABORATORY	275.00
IV-ENDODONTICS	
PULP CAP-DIRECT	10.00
PUPLOTOMY	60.00
ROOT CANAL THERAPY-1 CANAL	175.00
ROOT CANAL THERAPY-2 CANALS	235.00
ROOT CANAL THERAPY-3 CANALS	325.00
ROOT CANAL THERAPY-4 CANALS	375.00
APICOECTOMY-FIRST ROOT	130.00
APICOECTOMY, maximum per tooth	260.00
RETROGRADE FILLING-per tooth	85.00

	Plan Pays
V-PERIODONTICS	
GINGIVECTOMY, GINGIVOPLASTY and	
MUCOGINGIVAL SURGERY per quad	110.00
OSSEOUS SURGERY - per quad	350.00
OSSEOUS GRAFT-per site	125.00
OSSEOUS GRAFT-maximum per quadrant	225.00
PEDICLE SOFT TISSUE GRAFT	175.00
FREE SOFT TISSUE GRAFT	225.00
ROOT SCALING & GINGIVAL CURETTAGE	
per visit	30.00
occlusal adjustment complete	60.00
periodontal maintenance	55.00
VI-PROSTHODONTICS	
DENTURE immed. or permanet	400.00
PARTIAL DENTURE-ACRYLIC BASE	225.00
PARTIAL DENTURE-CAST BASE	400.00
UNILATERAL PARTIAL DENTURE	150.00
ADJUST DENTURE - complete or partial	25.00
REPAIR COMP DENT BASE	80.00
REPLC MISS/BRKN TTH-COM DENT	75.00
REPAIR PART ACRYLIC SADDLE/BASE	80.00
REPAIR CAST FRAMEWORK	95.00
REPAIR OR REPLACE BROKEN CLASP	75.00
ADD TTH TO EXISTING PART DENT	75.00
ADD CLASP TO EXISTING PART DENT	80.00
RELINE COMPLETE DENTURE-CHAIR	80.00
RELINE PARTIAL DENTURE-CHAIR	75.00
RELINE COMPLETE DENTURE-LAB	125.00
RELINE PARTIAL DENTURE-LAB	100.00
TISSUE CONDITIONING	40.00
PONTIC-CAST METAL	300.00
PONTIC-PORCELAIN TO METAL	375.00
PONTIC-RESIN WITH METAL	280.00
METAL INLAY 2 SURFACES	190.00
METAL INLAY 3 OR MORE SURFACE	230.00
ABUTMENT-RESIN WITH METAL	280.00
ABUTMENT-PORCELAIN WITH METAL	375.00
ABUTMENT-FULL CAST	300.00
RECEMENT BRIDGE	50.00
REPLACE FACING	100.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	30.00
SURGICAL EXTRACTION erupted tooth	60.00
retained root	90.00
IMPACTION-SOFT TISSUE	90.00
IMPACTION-PARTIAL BONY	140.00
IMPACTION-COMPLETE BONY	185.00
BIOPSY OF ORAL TISSUE	75.00
ALVEOPLASTY per quad	125.00
CYST REMOVAL < 1.25CM	75.00
CYST REMOVAL > 1.25CM.	125.00
INCISION & DRAINAGE INTRAORAL	50.00
FRENULECTOMY	85.00
HEMISECTION	150.00
ROOT RESECTION	150.00
GENERAL ANESTHESIA	90.00
VIII-ORTHODONTIC TREATMENT	
INITIAL APPLIANCE-INCL DIAGNOSIS	400.00
ACTIVE TREATMENT-PER MONTH	50.00
PASSIVE TREATMENT-PER 3 MONTHS	50.00
REMOVABLE APPLIANCE	225.00
HARMFUL HABIT APPLIANCE	225.00
POSTTREATMENT STABILIZATION	100.00