MID-JERSEY TRUCKING INDUSTRY AND LOCAL No. 701 WELFARE FUND
METRODENT PREMIER PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	• To confirm members eligibility please call the fund office at (732)-297-3900.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• The annual maximum per covered individual is $2,000 per calendar year, including orthodontic services.
DEDUCTIBLE	• There is no annual deductible
PLAN LIMITATIONS	• **Examination** –two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Replacement of Prosthetics (i.e. crowns, bridges and dentures)** – not more than once in thirty six months • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – Children and adults, maximum two applications per year • **Sealant –** unrestored permanent posterior teeth, to age 13, maximum two applications per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $240 per calendar year • **Orthodontic treatment –** Lifetime maximum benefit $1,750 per covered individual. Maximum 24 months active treatment, maximum 9 months passive treatment. Payment for orthodontic services are applied to the annual maximum. • **Osseous Surgery –** maximum of two quadrants per visit • **Incision & Drainage –** no other treatment that visit • **General Anesthesia/IV Sedation –** first 30 minutes only • **Specialist consultation –** one per calendar year
PRE-TREATMENT REVIEW	• This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. **Please note-** a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible • Pre-op periapical x-rays required for crowns, veneers, inlays and extractions • Periodontal charting and x-rays are required for surgical periodontal procedures • Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework
PERMISSIBLE CHARGES	• **Covered and reimbursable services, no co-payment:** None • **Covered and reimbursable services, with co-payment:** only established co-payment • **Covered but not reimbursable services:** Schedule allowance plus established co-payment or charges incurred do to frequency limitations • **Non-covered services:** 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. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate co-payments, deductibles, or charges levied due to maximums.
HOW TO FILE A CLAIM	• **As a participating provider, you must complete all necessary paper work and accept assignment of benefits. Dental claims must be filed within 6 months of the date of service.** • Complete a Claim Form **(computer generated, ADA, and universal claim forms are accepted)** and provide an itemized bill of services rendered. **Signature on file is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • **Mail claims to : MID-JERSEY TRUCKING INDUSTRY AND LOCAL No. 701** **2003 Route 130, Suite A** **North Brunswick, NJ 08902**
CLAIM INQUIRIES	**If you have any question regarding claim status or eligibility, please contact the Welfare Fund at:** MID-JERSEY TRUCKING INDUSTRY AND LOCAL No. 701 2003 Route 130, Suite A North Brunswick, NJ 08902 (732)-297-3900
PPO INQUIRIES	For up to date detailed information please access our website at: **www.asonet.com** If you have any questions regarding the operation of this program please contact S.I.D.S. at: (516) 396-5500 OR (800)-537-1238

Rev 1/10

Self-Insured Dental Services / Administrative Services Only, Inc. Dental Plan Administrators

Mid-Jersey Trucking Industry and Local No. 701 Welfare Fund
Schedule of Maximum Charges

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	17.00
PERIAPICAL X-RAY (EACH FILM)	5.00
OCCLUSAL FILM	25.00
EXTRAORAL	25.00
BITEWING-(EACH FILM)	5.00
POSTERIOR-ANTERIOR, LATERAL FILM	35.00
TEMPOROMANDIBULAR FILM	20.00
FULL MOUTH SERIES or PANORAMIC	40.00
CEPHALOMETRIC FILM	40.00
II-PREVENTIVE	
PROPHYLAXIS-ADULT	30.00
PROPHYLAXIS-CHILD	25.00
FLUORIDE EXCL. PROPHY	27.00
SEALANT-PER TOOTH	17.00
SPACE MAINTAINER	150.00
III-RESTORATIVE	
AMALGAM FILLINGS	
1 SURFACE	45.00
2 SURFACE	55.00
3 SURFACE	60.00
4 OR MORE SURFACES	65.00
COMPOSITE RESIN	
1 SURFACE	50.00
2 SURFACE	60.00
3 SURFACE	70.00
4 OR MORE SURF. INC INCISAL EDGE	80.00
METALLIC INLAY	
1 SURFACE	200.00
2 SURFACE	250.00
3 SURFACE	315.00
ONLAY IN ADDITION TO INLAY	70.00
PORCELAIN INLAY	
1 SURFACE	320.00
2 SURFACE	320.00
3 SURFACE	320.00
CROWNS	
ACRYLIC JACKET	175.00
PORCELAIN JACKET	350.00
PORCELAIN WITH METAL	425.00
PLASTIC WITH METAL	375.00
FULL OR 3/4 CAST	375.00
LABIAL VENEER-lab processed	275.00
STAINLESS STEEL CROWN,primary tooth	125.00
PIN RETENTION-PER TOOTH	25.00
PREFAB POST AND CORE	105.00
CAST POST AND CORE	125.00
IV-ORAL SURGERY	
SIMPLE EXTRACTION	50.00
SURGICAL EXTRACTION	
must be demonstrated by x-ray	
ERUPTED ROOT	75.00
RETAINED ROOT	90.00
IMPACTION-SOFT TISSUE	115.00
IMPACTION-PARTIAL BONY	185.00
IMPACTION-COMPLETE BONY	225.00
ALVEOPLASTY-per jaw	125.00
INCISION & DRAINAGE	50.00
BIOPSY OF ORAL TISSUE	75.00
CYST REMOVAL < 1.25CM	85.00
CYST REMOVAL > 1.25CM.	160.00
FRENULECTOMY	120.00
HEMISECTION/ROOT RESECTION	150.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT	30.00
CONSULTATION BY A SPECIALIST	50.00
GENERAL ANESTHESIA/IV SEDATION	125.00

	MAXIMUM CHARGE	
VI-PROSTHODONTICS		
DENTURE-PERMANENT OR IMMEDIATE	600.00	
PARTIAL DENTURE-ACRYLIC BASE	425.00	
PARTIAL DENTURE-CAST BASE	600.00	
UNILATERAL PARTIAL DENTURE	200.00	
DENTURE ADJUSTMENT	35.00	
REPAIR COMP DENT BASE	90.00	
REPLC MISS/BRKN TTH-COM DENT	85.00	
REPAIR PART ACRYLIC SADDLE/BASE	100.00	
REPAIR CAST FRAMEWORK	100.00	
REPAIR OR REPLACE BROKEN CLASP	85.00	
REPLACE BROKEN TEETH- PER TOOTH	85.00	
ADD TTH TO EXISTING PART DENT	85.00	
ADD CLASP TO EXISTING PART DENT	85.00	
REPLACE FACING	100.00	
RELINE COMPLETE DENTURE-CHAIR	75.00	
RELINE PARTIAL DENTURE-CHAIR	90.00	
RELINE COMPLETE DENTURE-LAB	125.00	
RELINE PARTIAL DENTURE-LAB	100.00	
TISSUE CONDITIONING	40.00	
RECEMENT BRIDGE or SPACE MAINTAINER	40.00	
RECEMENT INLAY or CROWN	30.00	
ABUTMENT-PLASTIC WITH METAL	375.00	
ABUTMENT-PORCELAIN WITH METAL	425.00	
ABUTMENT-FULL OR 3/4 CAST	350.00	
PONTIC-FULL CAST	350.00	
PONTIC-PORCELAIN TO METAL	425.00	
PONTIC-PLASTIC WITH METAL	375.00	
VII-PERIODONTICS		
GINGIVECTOMY, GINGIVOPLASTY OR		
MUCO-GINGIVAL SURGERY PER QUAD	105.00	
OSSEOUS SURGERY-PER QUAD	350.00	
OSSEOUS GRAFT-PER SITE	200.00	
OSSEOUS GRAFT, max per quadrant	250.00	
PEDICAL SOFT TISSUE GRAFT	250.00	
FREE SOFT TISSUE GRAFT	250.00	
OCCLUSAL ADJUSTMENT-LIMITED	35.00	
OCCLUSAL ADJUSTMENT-COMPLETE	120.00	
CURETTAGE, SCALE\ROOT PLANING-VISIT	60.00	
CURETTAGE, SCALE\ROOT PLANING-FM	60.00	
PERIODONTAL MAINTENANCE PROCEDURE	60.00	
VIII-ENDODONTICS		
PULP CAP, direct	25.00	
VITAL PULPOTOMY	60.00	
ROOT CANAL THERAPY - 1 canal	225.00	
ROOT CANAL THERAPY - 2 canals	275.00	
ROOT CANAL THERAPY - 3 canals	350.00	
ROOT CANAL THERAPY - 4 or more canals	400.00	
APICOECTOMY	200.00	
APICOECTOMY, maximum per tooth	400.00	
RETROGRADE FILLING	85.00	
VIII-ORTHODONTIC SERVICES		
MINOR TOOTH MOVEMENT & INTERCEPTIVE		
REMOVABLE APPLIANCE	**270.00**	*
FIXED APPLIANCE	**300.00**	*
ACTIVE TREATMENT, per month	60.00	
MAXMUM CHARGE PER CASE	**780.00**	
COMPREHENSIVE TREATMENT		
REMOVABLE APPLIANCE	**270.00**	*
FIXED APPLIANCE	**480.00**	*
ACTIVE TREATMENT, per month	60.00	
MAXIMUM 24 MONTHS		
PASSIVE TREATMENT - per 3 mths of treatm	60.00	
MAXIMUM 9 MONTHS		
POST-TREATMENT STABILIZATION DEVICE	120.00	
MAXIMUM CHARGE PER CASE	**2,520.00**	

The service indicated by an asterisk(*) require a $100 co-payment from the patient.