TEAMSTERS LOCAL 531 WELFARE FUND
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 eligibility please call American Group Administrators (800) 842-4742.
PLAN YEAR	• January 1 through December 31
ANNUAL MAXIMUM	• $750 per covered individual in a calendar year
PLAN OPERATION	• Plan pays 50% of schedule, member is responsible to pay the other 50% of fee schedule.
PLAN LIMITATIONS	• **Examination** – two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** one in twenty four months • **X-rays –** two series of bitewings per calendar year • **Replacement of prosthetics** – not more than once in five years • **Fluoride treatment** – to age 19, maximum one application per year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – • **Orthodontic treatment –** not reimbursable by fund, participating orthodontists provide a discount fee-for-service plan according to fee schedule
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:** None • **Covered but not reimbursable services:** Schedule allowance • **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.** • 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: American Group Administrators 101 Convention Center Drive Suite 200 Las Vegas, NV 89109

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 A.G.A. at:
(800) 842-4742

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

MetroDENT DENTAL NETWORK FOR
TEAMSTERS LOCAL 531

I-DIAGNOSTIC	MAXIMUM CHARGE
INITIAL ORAL EXAMINATION	20.00
PERIODIC ORAL EXAMINATION	15.00
PERIAPICAL X-RAY (EACH FILM)	3.00
OCCLUSAL FILM	10.00
EXTRAORAL- (EACH FILM)	25.00
BITEWING-(EACH FILM)	6.00
POSTERIOR-ANTERIOR, LATERAL, TMJ	25.00
FULL MOUTH SERIES or PANORAMIC	30.00
PALLIATIVE-EMERGENCY TRT	30.00
CONSULTATION BY A SPECIALIST	50.00
CEPHALOMETRIC FILM	35.00
II-PREVENTIVE	
PROPHYLAXIS-ADULT	30.00
PROPHYLAXIS-CHILD(to age 14)	20.00
FLUORIDE EXCL. PROPHY	15.00
SPACE MAINTAINER	100.00
III-RESTORATIVE	
AMALGAM - 1 SRF PERMANENT	30.00
AMALGAM - 2 SRF PERMANENT	40.00
AMALGAM - 3 SRF PERMANENT	50.00
AMALGAM - 4+ SRF PERMANENT	55.00
RESIN-1 SURFACE	35.00
RESIN-2 SURFACE	45.00
RESIN-3 SURFACE	50.00
RESIN-INCISAL ANGLE	60.00
METALLIC or PORCELAIN INLAY-1 SRF	150.00
METALLIC or PORCELAIN INLAY-2 SRF	190.00
METALLIC or PORCELAIN INLAY-3 SRF	230.00
ONLAY-METALLIC	40.00
CROWN-RESIN WITH METAL	325.00
CROWN-PORCELAIN JACKET	325.00
CROWN-PORCELAIN WITH METAL	375.00
GOLD FULL CAST CROWN	350.00
CROWN-3/4 CAST	350.00
PONTIC-CAST METAL	350.00
PONTIC-PORCELAIN TO METAL	375.00
PONTIC-RESIN WITH METAL	325.00
RECEMENT BRIDGE or SPACE MAINTAINER	40.00
RECEMENT INLAY or CROWN	20.00
PIN RETENTION-PER TOOTH	15.00
CAST POST AND CORE	95.00
PREFAB POST AND CORE	95.00
IV-PERIODONTICS	
GINGIVECTOMY-PER QUADRANT	225.00
OSSEOUS SURGERY-PER QUAD	350.00
OSSEOUS GRAFT-PER SITE	90.00
OSSEOUS GRAFT-PER QUAD	250.00
PEDICLE SOFT TISSUE GRAFT	200.00
FREE SOFT TISSUE GRAFT	250.00
CURETTAGE, SCALE\ROOT PLANING-VISIT	40.00
PERIODONTAL MAINTENANCE PROCEDURE	55.00

V-ENDODONTICS	MAXIMUM CHARGE
VITAL PULPOTOMY	70.00
ROOT CANAL THERAPY-1 CANAL	175.00
ROOT CANAL THERAPY-2 CANALS	350.00
ROOT CANAL THERAPY-3 CANALS	400.00
ROOT CANAL THERAPY-4 CANALS	400.00
APICOECTOMY-PER ROOT	210.00
APICOECTOMY-MAX PER TOOTH	350.00
ROOT RESECTION/HEMISECTION	105.00
VI-PROSTHODONTICS	
COMPLETE DENTURE	400.00
IMMEDIATE DENTURE	400.00
PARTIAL DENTURE-ACRYLIC BASE	225.00
PARTIAL DENTURE-CAST BASE	425.00
UNILATERAL PARTIAL DENTURE	150.00
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
RELINE COMPLETE DENTURE-CHAIR	90.00
RELINE PARTIAL DENTURE-CHAIR	75.00
RELINE COMPLETE DENTURE-LAB	130.00
RELINE PARTIAL DENTURE-LAB	100.00
REPLACE FACING	75.00
PRECISION ATTACHMENT	125.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	30.00
SURGICAL EXTRACTION	60.00
IMPACTION-SOFT TISSUE	100.00
IMPACTION-PARTIAL BONY	140.00
IMPACTION-COMPLETE BONY	185.00
ROOT AMPUTATION	210.00
ALVEOPLASTY-PER QUAD	125.00
INCISION & DRAINAGE	50.00
BIOPSY OF ORAL TISSUE	75.00
CYST REMOVAL < 1.25CM	75.00
CYST REMOVAL > 1.25CM.	90.00
FRENULECTOMY	100.00
GENERAL ANESTHESIA	90.00
VIII-ORTHODONTIC SERVICES	
FIXED APPLIANCE	550.00
ACTIVE TREATMENT, PER MONTH	67.00
PASSIVE TREATMENT, PER 3 MONTHS	50.00

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