ROSLYN TEACHERS ASSOCIATION BENEFIT FUND
ROSLYN / 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	• All employees of the Roslyn Union Free School District whose employment is subject to a Collective Bargaining Agreement by and between the Board and the Roslyn Teachers Association Benefit Fund, and all other employees who may be deemed eligible by the Trustees of the Benefit Fund • **Eligible dependents**: Spouses and unmarried dependent children who have not yet attained their 19th birthday or 25th birthday if attending an accredited school or college on a full-time basis.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $3,000 per covered individual per calendar year
DEDUCTIBLE	• There is no deductible
PLAN LIMITATIONS	• **Examination** – two per calendar year • **Prophylaxis** –4 per calendar year not to exceed one every 3 months • **X-rays** – $135 maximum in a calendar year • **Cone Beam** - one per 24 months • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – maximum two application per calendar year • **Sealant –** unrestored posterior teeth, to age 16, lifetime maximum of $90 per quadrant • **Root Scaling, Gingival Curettage, Bite Correction, Full Mouth Debridement and/or Periodontal Maintenance –** maximum of 2 quadrants payable per visit. Maximum $400 per calendar year • **Replacement of prosthetics –** once in 5 years • **Osseous Surgery –** maximum of 2 quadrants payable per visit. 1 in 36 consecutive months, based on the number of teeth involved • **Orthodontic treatment –** lifetime maximum is $2,500 per covered individual • **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
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, however payment from the other plan must first be applied to reduce or eliminate co-payments 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 : Administrative Services Only, Inc P.O. Box 9005 Dept 106 Lynbrook, NY 11563 • **Filing deadline**: March 31st of the following year in which services occurred. • File claims electronically: **PAYOR ID: CX076**

For up to date detailed information, including member eligibility, 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 (718) 204-7172

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

ROSLYN TEACHERS ASSOCIATION BENEFIT FUND
SCHEDULE OF ALLOWANCES

	Maximum Charge
I-DIAGNOSTIC	
ORAL EXAM	50.00
FIRST PERIAPICAL X-RAY	12.00
TWO BITEWING X-RAYS	21.00
FOUR BITEWING X-RAYS	37.00
OCCLUSAL FILM	25.00
POSTERIOR-ANTERIOR, LATERAL	25.00
PANORAMIC	60.00
FULL MOUTH SERIES	65.00
CEPHALOMETRIC FILM	50.00
DIAGNOSTIC CASTS	60.00
CONE BEAM	250.00
II-PREVENTIVE	
PROPHYLAXIS-adult	70.00
PROPHYLAXIS-child up to age 16	55.00
FLUORIDE EXCL PROPHY	30.00
SEALANT-PER TOOTH	27.00
SPACE MAINTAINER-FIXED	175.00
III-RESTORATIVE	
AMALGAM - 1 SRF-permanent tooth	95.00
AMALGAM - 2 SRF-permanent tooth	100.00
AMALGAM - 3 SRF-permanent tooth	120.00
AMALGAM - 4+ SRF-permanent tooth	130.00
RESIN-1 SRF-anterior	95.00
RESIN-2 SRF-anterior	120.00
RESIN-3 SRF-anterior	140.00
RESIN-4 SRF & INCISAL ANGLE	155.00
RESIN-1 SRF-posterior	100.00
RESIN-2 SRF-posterior	130.00
RESIN-3 SRF-posterior	155.00
RESIN-4 OR MORE SRF-posterior	175.00
METALLIC INLAY-1 SRF	275.00
METALLIC INLAY-2 SRF	325.00
METALLIC INLAY-3 SRF	460.00
CROWN-PLASTIC	255.00
CROWN-RESIN WITH BASE METAL	580.00
CROWN-PORCELAIN	620.00
CROWN-PORCELAIN WITH METAL	630.00
CAST METL RETNR-ACID ETCH BRIDGE	230.00
RECEMENT BRIDGE	66.00
RECEMENT INLAY	50.00
RECEMENT CROWN	45.00
PREFAB SS CROWN-PRIMARY	130.00
PIN RETENTION-PER TOOTH	35.00
CAST POST AND CORE	225.00
PREFAB POST AND CORE	200.00
PORCELAIN LAMINATE	425.00
CUSTOM ABUTMENT	475.00
ABUTMENT SUPPORTED CROWN	675.00
IMPLANT SUPPORTED CROWN	975.00
IV-ENDODONTICS	
PULP CAP	40.00
VITAL PULPOTOMY	90.00
ROOT CANAL THERAPY-1 CANAL	475.00
ROOT CANAL THERAPY-2 CANALS	525.00
ROOT CANAL THERAPY-3 CANALS	600.00
RETREATMENT RCT-1 CANAL	560.00
RETREATMENT RCT-2 CANAL	625.00
RETREATMENT RCT-3 CANAL	665.00
APICOECTOMY-PER ROOT	310.00
APICOECTOMY-MAX PER TOOTH	450.00
RETROGRADE FILLING	85.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE-EMERGENCY TRT	65.00
CONSULTATION BY A SPECIALIST	75.00
GENERAL ANESTHESIA per 15 minutes	100.00
ANESTHESIA IV SEDATION per 15 minute	100.00

	Maximum Charge
VI-PERIODONTICS	
GINGIVECTOMY-PER QUADRANT	230.00
OSSEOUS SURGERY-PER QUAD	625.00
PEDICLE SOFT TISSUE GRAFT	230.00
FREE SOFT TISSUE GRAFT	435.00
OSSEOUS GRAFT-PER SITE	200.00
OCCLUSAL ADJUSTMENT-LIMITED	75.00
OCCLUSAL ADJUSTMENT-COMPLETE	200.00
SCALE\ROOT PLANING-VISIT	230.00
PERIODONTAL MAINTENANCE PROCEDURE	80.00
VII-PROSTHODONTICS	
COMPLETE OR IMMEDIATE DENTURE	750.00
PARTIAL DENTURE-ACRYLIC BASE	700.00
PARTIAL DENTURE-CAST BASE	785.00
UNILATERAL PARTIAL DENTURE	300.00
DENTURE ADJUSTMENT-COMPLETE	50.00
DENTURE ADJUSTMENT-PARTIAL	50.00
REPAIR COMP DENT BASE	100.00
REPLC MISS/BRKN TTH-COM DENT	100.00
REPAIR PART ACRYLIC SADDLE/BASE	100.00
REPAIR CAST FRAMEWORK	100.00
REPAIR OR REPLACE BROKEN CLASP	100.00
REPLACE BROKEN TEETH- PER TOOTH	90.00
ADD CLASP TO EXISTING PART DENT	140.00
ADD TOOTH TO EXISTING PART DENT	105.00
RELINE COMPLETE DENTURE-CHAIR	175.00
RELINE PARTIAL DENTURE-CHAIR	165.00
RELINE COMPLETE DENTURE-LAB	175.00
RELINE PARTIAL DENTURE-LAB	200.00
TISSUE CONDITIONING	130.00
ABUTMENT-RESIN WITH BASE METAL	475.00
ABUTMENT-PORCELAIN FUSED TO METAL	575.00
ABUTMENT- CAST NOBLE METAL	505.00
PONTIC-RESIN WITH BASE METAL	450.00
PONTIC-PORCELAIN FUSED TO METAL	575.00
PONTIC-CAST NOBLE METAL	510.00
REPLACE FACING	110.00
VIII-ORAL SURGERY	
SIMPLE EXTRACTION	150.00
SURGICAL EXTRACTION	220.00
IMPACTION-SOFT TISSUE	240.00
IMPACTION-PARTIAL BONY	310.00
IMPACTION-COMPLETE BONY	360.00
SURGICAL EXPOSURE-ORTHO	330.00
SURGICAL EXPOSURE-AID ERUPTION	325.00
DEVICE TO AID ERUPTION	200.00
ROOT RECOVERY	150.00
ALVEOPLASTY	110.00
INCISION & DRAINAGE-no other treatment that vis	85.00
BIOPSY OF ORAL TISSUE	100.00
CYST REMOVAL <1.25CM	175.00
CYST REMOVAL > 1.25CM	190.00
FRENULECTOMY	220.00
ROOT RESECTION	225.00
IX-IMPLANTSERVICES	
ENDOSTEAL IMPLANT	1200.00
EPOSTEAL/ SUBPERIOSTEAL IMPLANT	1200.00
DEBRIDEMENT/OSSEOUS CONT. PERI IMPLANT	300.00
DEBRIDEMENT OF PERI-IMPLANT DEFECT	300.00
BONE GRAFT RIDGE PRESERVATION	300.00
BONEGRAFT-REPAIR PERI IMPLANT	300.00
BONEGRAFT WHILE IMPLANT PLACEMENT	300.00
X-ORTHODONTIC SERVICES	
COMPREHENSIVE TREATMENT	
REMOVABLE/ HARMFUL HABIT APPLIANCE	270.00
FIXED APPLIANCE	900.00
ACTIVE TREATMENT, PER MONTH	100.00
PASSIVE TREATMENT, PER 3 MONTHS	100.00
POST-TREATMENT STABILIZATION DEVICE	120.00