NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION
METRODENT PREMIER PLUS 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 Unified Court System who are regular full time employees and are covered by a collective bargaining agreement between the Ninth Judicial District Court Employees Association and the State of New York – Unified Court System • **Eligible dependents**: Include the lawful spouse and each dependent child until the age 26 is reached.
PLAN YEAR	• April 1 through March 31
PLAN MAXIMUM	• $2,500 per covered individual and $5,000 per family in a plan year
DEDUCTIBLE	• There is no plan deductible
PLAN LIMITATIONS	• **Examination** – two in a plan year • **Prophylaxis** – three in a plan year over the age of 16, two in a plan year up to the age of 16 • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Implants** – 2 per arch per lifetime • **Replacement of crowns, bridges and dentures –** not more than once in 5 years • **Fluoride treatment** – to age 16, one application per year • **Sealant –** unrestored posterior teeth, to age 16, lifetime maximum 1 application per tooth • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $300 per calendar year-max 2 quads per day • **Orthodontic treatment –** $3,000 lifetime benefit, per covered individual. Maximum charge per case is $4,000. • **Specialist consultation –** maximum one per plan year, includes allowance for examination
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. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting

Mail claims to : Administrative Services Only, Inc
P.O. Box 9005 Dept. 11
Lynbrook N.Y. 11563
File claims electronically: **PAYOR ID: CX076**

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 (718) 204-7172

Rev 6/23

NINTH JUDICIAL DISTRICT COURT EMPLOYESS ASSOCIATION SCHEDULE OF ALLOWANCES

Description	Plan Pays	Copay
DIAGNOSTIC & PREVENTIVE		
PERIODIC ORAL EXAMINATION	30	
X-RAYS-FULL MOUTH	60	
BW or PA X-RAY FIRST FILM	10	
BW oR PA X-RAY -ADDITIONAL	6	
0CCLUSAL FILM	15	
XRAY-EXTRAORAL	35	
VERTICAL BITEWINGS 7-8 FILMS	35	
X-RAY ANT. POST. OR LATERAL	25	
PANORAMIC FILM	50	
CEPHALOMETRIC FILM	50	
ORAL/FACIAL IMAGES	25	
CONE BEAM CT SCANS	100	100
PULP VITALITY TEST	20	
DIAGNOSTIC CASTS	40	
PROPHYLAXIS ADULT	60	
PROPHYLAXIS-CHILD TO AGE 16	45	
FLUORIDE TREATMENT-TO AGE 16	20	
SEALANT-TO AGE 16	25	
SPACE MAINTAINER- FIXED -BILATERAL	225	
SPACE MAINTAINER -REMOVABLE -BILATERAL	250	
RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER	40	
RESTORATIVE		
AMALGAM ONE SURFACE -PERMANENT OR PRIMARY	55	
AMALGAM TWO SURFACES-PERMANENT OR PRIMARY	70	
AMALGAM THREE SURFACES-PERM OR PRIME	80	
AMALGAM-FOUR OR MORE SURFACES PERM OR PRIM	95	
RESIN - ONE SURFACE	60	
RESIN - TWO SURFACES	75	
RESIN THREE OR MORE SURFACES	90	
RESIN-4+ SRF OR INCISAL EDGE	100	
RESIN 1 SURFACE POSTERIOR	75	
RESIN-2 SURFACES,POSTERIOR	100	
RESIN-3 SURFACES,POST.	115	
RESIN-4 OR MORE SRF-POST	125	
CAST RESTORATIONS -CROWNS AND BRIDGES-		
MAX ONE PER TOOTH IN A 5 YEAR PERIOD		
INLAY-METALLIC -ONE SURFACE	275	
INLAY METALLIC -TWO SURFACES	350	
INLAY-METALLIC-THREE OR MORE S	375	
ONLAY-METALLIC 2 SURFACE	400	
ONLAY-METALLIC 3 SURFACE	450	
INLAY-PORCELAIN 1 SURFACE	350	
INLAY-PORCELAIN 2 SURFACES	425	
INLAY-PORCELAIN-3 OR MORE SURF	500	
ONLAY-PORCELAIN/CERAMIC 2 SURFACE	400	
ONLAY-PORCELAIN/CERA,IC 3 or more SURFACE	500	
CROWN-RESIN (LABORATORY)	200	
CROWN RESIN WITH METAL	500	
CROWN ? PORCELAIN/CERAMIC SUBSTRATE	550	
CROWN-PORC.FUSED TO METAL	625	
CROWN-PORC.FUSED TO BASE METAL	575	
CROWN-PORC.FUSED TO NOBLE META	625	
CROWN - TITANIUM OR TITANIUM ALLOYS	575	
CROWN - 3/4 CAST HIGH NOBLE METAL	550	
CROWN-3/4 CAST BASE OR NOBLE METAL	500	
CROWN-3/4 PORCELAIN/CERAMIC	475	
CROWN-FULL CAST METAL	500	
CROWN-FULL CAST BASE OR NOBLE METAL	475	
CROWN-TITANIUM	525	
RECEMENT INLAY	40	
RECEMENT CROWN	50	
PREFABRICATED SS CROWN-PRIMARY	100	
STAINLESS STEEL CROWN-PERM	100	
PREFAB. RESIN CROWN	100	
PREFAB SS CROWN W/RESIN WINDOW	150	
PROTECTIVE RESTORATION	40	
CROWN BUILD-UP	75	
PIN SUPPORT PER TOOTH	30	
CAST POST & CORE	160	
PREFAB POST & CORE	120	
RESIN LAMINATE-LABORATORY	250	
PORCELAIN LAMINATE	375	
VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL	100	
ENDODONTICS		
PULP CAP-DIRECT	30	
PULP CAP-INDIRECT	20	
VITAL PULPOTOMY	80	
PULPAL DEBRIDEMENT	40	
PARTIAL PULPOTOMY FOR APEXOGENESIS	75	
PULPAL THERAPY-PRIMARY-ANTERIO	150	
PULPAL THERAPY-PRIMARY-POSTERI	200	
ROOT CANAL THERAPY-ANTERIOR TOOTH	350	
ROOT CANAL THERAPY-BICUSPID TOOTH	425	
ROOT CANAL THERAPY-MOLAR TOOTH	700	
TX OF ROOT CANAL OBSTRUCTION	125	
INCOMPLETE ENDODONTIC THERAPY	175	
RETREATMENT-RCT -ANTERIOR	550	
RETREATMENT OF RCT - BICUSPID	650	
RETREATMENT RCT-MOLAR	850	
APICOECTOMY-FIRST ROOT	250	
APICO.-PREMOLAR-FIRST ROOT	250	
APICO.-MOLAR-FIRST ROOT	250	
APICOECTOMY-EACH ADDITIONAL RT	150	
RETROGRADE FILLING	100	
ROOT RESECTION	200	
HEMISECTION	200	
ADJUNCTIVE SERVICES		
SPECIALIST CONSULTATION	65	
OCCLUSAL GUARD	150	
PALLIATIVE TREATMENT	40	

Description	Plan Pays	Copay
PERIODONTICS		
GINGIVECTOMY OR GINGIVOPLASTY	250	
GINGIVECTOMY ONE TO THREE TEETH-PER QUAD	150	
OSSEOUS SURGERY-PER QUADRANT	550	
OSSEOUS SURGERY 1 -3 TEETH	330	
OSSEOUS GRAFT- PER SITE	150	
PEDICLE SOFT TISSUE GRAFTS	300	
FREE SOFT TISSUE GRAFT	325	
PERIO TREATMENT PER QUAD	75	
SCALING-ROOT PLANING 1 TO 3 TEETH	45	
FULL MOUTH DEBRIDEMENT	50	
PERIODONTAL MAINTENANCE	75	
DENTURES AND FIXED BRDIGES		
COMPLETE DENTURE	750	
IMMEDIATE FULL DENTURE	750	
PARTIAL DENTUREL-ACRYLIC BASE W/C	550	
PARTIAL DENTURE - CAST METAL	750	
REMOVABLE UNILATERAL PARTIAL DENTURE	275	
ADJUST COMPLETE DENTURE	55	
REPAIR BROKEN COMPLETE DENTURE BASE	125	
REPLACE BROKEN TTH IN DENTURE	100	
REPAIR RESIN PARTIAL DENTURE BASE	100	
REPAIR CAST PARTIAL FRAMEWORK	115	
REPAIR OR REPLACE BROKEN CLASP	85	
REPLACE BROKEN TOOTH	95	
ADD TOOTH TO DENTURE	95	
ADD CLASP TO EXIST PART DENT	105	
REBASE FULL UPPER	165	
RELINE COMPLETE DENTURE (CHAIRSIDE)	120	
RELINE PARTIAL DENTURE (CHAIRSIDE)	105	
RELINE COMPLETE DENTURE-LAB	165	
RELINE PARTIAL DENTURE-LAB	150	
PONTIC CAST GOLD	500	
PONTIC PORC FUSED TO METAL	550	
PONTIC-PORC.FUSED TO BASE OR NOBLE MET	525	
PONTIC-PORCELAIN/CERAMIC	550	
PONTIC RESIN WITH METAL	500	
MARYLAND BRIDGE RETAINER	350	
RETAINER - PORCELN/CERAMIC RSN BONDED FI	350	
ABUTMENT RESIN WITH METAL	500	
ABUTMENT-PORCELAIN JACKET	550	
ABUTMENT-PORC. FUSED TO METAL	625	
ABUTMENT-PORC.FUSED TO BASE ME	575	
ABUTMENT-PORC.FUSED TO NOBLE M	625	
ABUTMENT-3/4 OR FUL CAST NOBLE METAL	500	
RECEMENT BRIDGE	75	
IMPLANTOLOGY-2 PER ARCH PER LIFETIME		
ENDOSTEAL IMPLANT	700	700
PREFABRICATED ABUTMENT	250	250
CUSTOM ABUTMENT	250	250
ABUTMENT SUPPORTED PORC/CER CR	500	250
ABUTMENT SUPPORTED PORC/MET CR	500	250
ABUT SUPPORTED CRWN-BASE METAL	500	250
ABUTMENT SUPPORTED CROWN	475	250
ABUTMENT SUP CAST HIGH NOBEL	500	250
ABUTMENT SUPPORTED BASE METAL	475	250
ABUTMENT SUPP CAST NOBLE CR	465	250
IMPLANT SUPPORTED PORC/CER CR	750	250
IMPLANT SUP PORC/HIGH NOBEL	750	250
IMPLANT SUPP HIGH NOBLE METL	500	250
ABUT SUPPRT RETAINR-PORC/CERAMC FPD	475	250
ABUT SUPRTD RETNR-PORC FUSD MET FPD	475	250
ABUTMENT SUPPORTED CROWN-BASE METAL	475	250
ABUT SUPPORTED RETAINER PORCELN FUSED ME	500	250
ABUTMENT SUPPORTED RETAINER FOR CAST MET	400	250
ABUTMENT SUPPORTED CROWN-CAST METAL	350	250
ABUTMENT SUPPORTED CROWN-NOBLE METAL	400	250
IMPL SUPP RETAIN FOR CERAM FPD	450	250
IMPL SUPP RETAIN FOR PORC FPD	435	250
IMPL SUPP RETAIN FOR TITAN FPD	425	250
RCMNT IMP/ABUT SUPPORTED CRWN	50	
BONE GRAFT AT TIME OF IMPLANT PLACEMENT	150	150
FIXED PARTIAL DENTURE REPAIR NECESSITATED BY	100	
EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	75	
SURGICAL EXTRACTION	100	
REMOVAL-SOFT TISSUE IMPACTED	200	
REMOVAL-PARTIAL BONY IMPACTED	275	
REMOVAL-COMPLETE BONY IMPACTED	300	
REMOVAL OF RESIDUAL ROOTS	110	
SURG.EXP-IMP/UNERUP(FOR ORTHO)	200	
Mobilization of Tooth to Aid Eruption	200	
DEVICE TO AID ERUPTION OF IMP	100	
BIOPSY HARD TISSUE	150	
BIOPSY SOFT TISSUE	125	
ALVEOLECTOMY	140	
ALVEOLOPLASTY W/EXT PER QD-1 TO 3 TEETH	84	
CYST/TUMOR REMOVAL < 1.25 CM	125	
CYST OR TUMOR REM- > 1.25 CM	200	
INCISION AND DRAINAGE	75	
BONE GRAFT	150	150
FRENECTOMY (FRENULECTOMY)	150	
ORTHODONTICS		
INITIAL ORTHO APP	800	
REMOVABLE APPLIANCE THERAPY	350	
ACTIVE ORTHO TREAT PER MONTH	100	
ORTHO RETENTION (REMOV APP, CONSTR/PLACE RE	250	
REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	100	
PALLIATIVE TREATMENT	40	
DEEP SEDATION/GENERAL ANESTHESIA ? FIRST 15 M	85	
INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/A	85	
per 15 minutes max 30 minutes		