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

TEAMSTERS LOCAL 1205 WELFARE FUND
METRODENT PREMIER PPO NETWORK PLAN A
PLAN DESCRIPTION & FEE SCHEDULE

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

ELIGIBILITY	• **Eligible dependents** include spouses, unmarried children who have not yet attained their 19th birthday or 23rd birthday if attending an accredited school or college on a full-time basis.
PLAN YEAR	• January 1 st through December 31 st
ANNUAL MAXIMUM	• $2,000 per covered individual in a calendar year
PLAN LIMITATIONS	• **Examination** – two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Palliative treatment** – no other treatment given that same visit • **Sealant** – permanent posterior teeth only, to age 19, one application in lifetime of tooth • **Fluoride treatment** – to age 19, maximum two applications per calendar year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $165 in a calendar year • **Replacement of Dentures** –partial or full dentures - not more than once in four years • **Replacement of Crown and Fixed Bridge** –not more than once in five years • **Orthodontics** – Lifetime maximum $2,160 per covered dependent, to age 19 • **Denture Adjustment –** one per year after first year of insertion • **Osseous surgery or graft –** maximum per quadrant one in 36 months • **Missing Tooth –** during the first year of eligibility there is no coverage for the replacement of a missing tooth • **Specialist Consultation –** maximum 1 per calendar 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:** no surcharge permitted • **Covered but not reimbursable service:** scheduled allowance • **Non-covered service:** 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 any benefits from the secondary 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 : Self-Insured Dental Services, Dept. 70 P.O. Box 9005 Lynbrook, NY 11563 • 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

Rev 1/11

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MetroDENT Premier Dental Network Plan A
TEAMSTERS LOCAL 1205 WELFARE FUND
SCHEDULE OF MAXIMUM CHARGES

	Plan Pays
I-DIAGNOSTIC	
ORAL EXAM	17.00
OCCLUSAL FILM	10.00
EXTRAORAL- (EACH FILM)	25.00
PA OR BITEWING X-RAYS-(PER FILM)	5.00
POSTERIOR-ANTERIOR, LATERAL TMJ	25.00
FULL MOUTH SERIES or PANORAMIC	40.00
CEPHALOMETRIC FILM	40.00
PALLIATIVE-EMERGENCY TRT	30.00
SPECIALIST CONSULTATION	50.00
II-PREVENTIVE	
PROPHYLAXIS-ADULT	30.00
PROPHYLAXIS-CHILD(to age 13)	25.00
FLUORIDE EXCL. PROPHY	10.00
SEALANT-PER TOOTH	15.00
SPACE MAINTAINER	150.00
III-RESTORATIVE	
AMALGAM - 1 SRF	45.00
AMALGAM - 2 SRF	55.00
AMALGAM - 3 SRF	60.00
AMALGAM - 4+ SRF	65.00
RESIN-1 SURFACE	50.00
RESIN-2 SURFACE	60.00
RESIN-3 OR MORE SURFACES	70.00
RESIN-4 SURF INCL INCISAL ANGLE	80.00
PIN RETENTION-PER TOOTH	25.00
METALLIC INLAY-1SRF	200.00
METALLIC INLAY-2 SRF	230.00
METALLIC INLAY-3 SRF	260.00
PORCELAIN INLAY - 1 SRF	200.00
PORCELAIN INLAY - 2 SRF	230.00
PORCELAIN INLAY - 3 SRF	260.00
CROWN-ACRYLIC JACKET	175.00
CROWN-ACRYLIC WITH METAL	375.00
CROWN-PORCELAIN JACKET	350.00
CROWN-PORCELAIN WITH METAL	425.00
GOLD FULL CAST CROWN	350.00
CROWN-3/4 CAST	350.00
PONTIC-CAST METAL	350.00
PONTIC-PORCELAIN TO METAL	425.00
PONTIC-RESIN WITH METAL	375.00
PONTIC-PLASTIC WITH METAL	375.00
CAST METL RETNR-ACID ETCH BRIDGE	230.00
RECEMENT BRIDGE/SP MAINTAINER	40.00
RECEMENT INLAY or CROWN	30.00
PREFAB SS CROWN-PRIMARY	75.00
CAST POST AND CORE	125.00
PREFAB POST AND CORE	75.00
LABIAL VENEER	275.00
IV-PERIODONTICS	
GINGIVECTOMY-PER QUADRANT	100.00
OSSEOUS SURGERY-PER QUAD	350.00
OSSEOUS GRAFT-PER SITE	90.00
OSSEOUS GRAFT-PER QUAD	250.00
PEDICLE SOFT TISSUE GRAFT	250.00
FREE SOFT TISSUE GRAFT	250.00
CURET, SCALE/ROOT PLAN-PER VISIT	50.00
PERIODONTAL MAINTENANCE PROC	55.00
OCCLUSAL ADJUSTMENT	40.00

	Plan Pays
V-ENDODONTICS	
PULP CAP	10.00
VITAL PULPOTOMY	60.00
ROOT CANAL THERAPY-1 CANAL	275.00
ROOT CANAL THERAPY-2 CANALS	325.00
ROOT CANAL THERAPY-3 CANALS	425.00
APICOECTOMY-PER ROOT	130.00
APICOECTOMY-MAX PER TTH	260.00
RETROGRADE FILLING	85.00
ROOT RESECTION/HEMISECTION	150.00
VI-PROSTHODONTICS	
COMPLETE/IMMEDIATE DENTURE	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	90.00
REPAIR CAST FRAMEWORK	100.00
REPAIR OR REPLACE BROKEN CLASP	85.00
REPLACE BROKEN TEETH-PER TTH	85.00
ADD TTH TO EXISTING PART DENT	85.00
ADD CLASP TO EXISTING PART DENT	85.00
RELINE COMPLETE DENTURE-CHAIR	75.00
RELINE PARTIAL DENTURE-CHAIR	75.00
RELINE COMPLETE DENTURE-LAB	125.00
RELINE PARTIAL DENTURE-LAB	100.00
REPLACE FACING	100.00
TISSUE CONDITIONING	40.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	50.00
SURGICAL EXTRACTION	75.00
IMPACTION-SOFT TISSUE	115.00
IMPACTION-PARTIAL BONY	185.00
IMPACTION-COMPLETE BONY	225.00
EXPOSURE OF TTH-AID ERUPTION	80.00
EXPOSURE OF TTH-FOR ORTHO	160.00
ROOT RECOVERY	90.00
ALVEOPLASTY-PER QUAD	125.00
BIOPSY OF ORAL TISSUE	75.00
CYST REMOVAL < 1.25CM	75.00
CYST REMOVAL > 1.25CM	125.00
INCISION AND DRAINAGE	50.00
FRENULECTOMY	95.00
GENERAL ANESTHESIA-1st 30mins.	125.00
VIII-ORTHODONTIC SERVICES	
DIAGNOSIS & INITIAL APPLIANCE	480.00
ACTIVE TREATMENT, PER MONTH	65.00
PASSIVE TREATMENT, PER 3 MTHS	65.00
REMOVABLE APPLIANCE	270.00
HARMFUL HABIT APPLIANCE	270.00
POST-TREAT STAB DEVICE	120.00