

**LOCAL 807 LABOR MANAGEMENT HEALTH 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	<ul style="list-style-type: none"> Includes the lawful spouse and each dependent child from birth until the age of 26 is reached so long as they are not covered by or eligible for other health insurance through their employer and have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
PLAN YEAR	<ul style="list-style-type: none"> January 1 st through December 31 st
ANNUAL MAXIMUM	<ul style="list-style-type: none"> The annual maximum is \$2,500 per person
DEDUCTIBLE	<ul style="list-style-type: none"> There is no deductible
WAITING PERIOD	<ul style="list-style-type: none"> There is a 6 month waiting period from the date of eligibility for crowns/ prosthetic devices and orthodontics
PLAN LIMITATIONS	<ul style="list-style-type: none"> Examination – two in a calendar year Prophylaxis – two in a calendar year X-rays – panoramic or full mouth series – one in 24 consecutive months Sealant –posterior teeth, to age 19, lifetime maximum one application per lifetime. Fluoride treatment – to age 19, maximum two applications per year Palliative treatment – no other treatment that same visit Root Scaling, curettage, bite correction; any combination, including prophylaxis – maximum two quadrants per visit, 4 treatments per year Specialist consultation – one per year, per specialty, includes allowance for examination Replacement of crowns, bridges and dentures – not more than once in 5 years General Anesthesia/IV Sedation – First 30 minutes only Orthodontics – 25 active months and 9 passive months for each individual to age 19 Incision & drainage – no other treatment that visit
PRE-TREATMENT REVIEW	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Covered and reimbursable services, no co-payment: None Covered and reimbursable services, with co-payment: Only established co-payments Covered but not reimbursable services: Schedule allowance Non-covered services: Your usual charge for that service
COORDINATION OF BENEFITS	<ul style="list-style-type: none"> 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 and customary charge.
HOW TO FILE A CLAIM	<ul style="list-style-type: none"> 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. 75 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

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

Dental Plan Administrators

Local 807 Labor Management Health Fund Dental Schedule of Allowances

	PLAN PAYS	MEMBER CO-PAY		PLAN PAYS	MEMBER CO-PAY
<u>DIAGNOSTIC</u>			<u>PERIODONTICS</u>		
ORAL EXAM	17.00		PERIO SCALE-PER QUAD	50.00	
FULL MOUTH SERIES	40.00		maximum 2 quadrants per visit		
PANORAMIC FILM	45.00		OCCLUSAL ADJUSTMENT	75.00	
INTRAORAL X-RAY , first film	5.00		PERIO MAINTENANCE		
INTRAORAL X-RAY, each additional film	5.00		following periodontal surgery	75.00	
BITEWING, per film	5.00		BRUXISM APPLIANCE	200.00	
OCCLUSAL FILM	15.00		GINGIVECTOMY, GINGIVAL FLAP OR MUCO-		
EXTRAORAL, TMJ FILM	25.00		GINGIVAL SURGERY PER QUAD	200.00	50.00
POSTERIOR-ANTER., LATERAL	25.00		FREE SOFT GRAFT-PER QUAD	250.00	
CEPHALOMETRIC FILM	40.00		OSSEOUS GRAFT-PER SITE	125.00	
			OSSEOUS GRAFT, MAX PER QUAD	250.00	
<u>PREVENTIVE</u>			OSSEOUS SURGERY including gingivectomy		
PROPHYLAXIS-ADULT	30.00		per quadrant	300.00	50.00
PROPHYLAXIS-CHILD	25.00		PEDICLE SOFT TISSUE GRAFT	200.00	
FLUORIDE EXCL. PROPHY	20.00				
SEALANT-PER TOOTH	20.00		<u>PROSTHODONTICS</u>		
SPACE MAINTAINER	150.00		DENTURE-PERMANENT OR IMMEDIATE	550.00	50.00
			PARTIAL DENTURE-ACRYLIC BASE	375.00	50.00
<u>RESTORATIVE</u>			PARTIAL DENTURE-CAST BASE	425.00	50.00
AMALGAM FILLINGS PRIMARY OR PERMANENT			UNILATERAL PARTIAL DENTURE	150.00	50.00
one surface	35.00	10.00	ADJUST DENTURE COM. OR PARTIAL	35.00	
two surfaces	45.00	10.00	REPAIR PART ACRYLIC SADDLE/BASE	75.00	
three surfaces	50.00	10.00	REPAIR CAST FRAMEWORK	100.00	
four surfaces	55.00	10.00	BROKEN DENTURE BASE	90.00	
SEDATIVE FILLING	20.00		REPLACE BROKEN TOOTH	85.00	
COMPOSITE RESIN-ANTERIOR OR POSTERIOR			REPLACE BROKEN FACING	100.00	
one surface	40.00	10.00	REPLACE BROKEN CLASP	85.00	
two surface	50.00	10.00	ADD TOOTH TO EXISTING PARTIAL DENT	85.00	
three or more surfaces	60.00	10.00	ADD CLASP TO EXISTING PART DENT	85.00	
incisal angle	70.00	10.00	RELINE COMPLETE DENTURE-CHAIR	75.00	
METALLIC INLAY			RELINE PARTIAL DENTURE-CHAIR	60.00	
one surface	200.00		RELINE COMPLETE DENTURE-LAB	125.00	
two surfaces	230.00		RELINE PARTIAL DENTURE-LAB	100.00	
three surfaces	260.00		PONTIC-FULL CAST	300.00	50.00
METALLIC ONLAY	70.00		PONTIC-PORCELAIN TO METAL	375.00	50.00
PORCELAIN INLAY			PONTIC-RESIN WITH METAL	300.00	50.00
one surface	200.00		CAST METAL RETR-ACID ETCH BRIDGE	230.00	
two surfaces	230.00		TISSUE CONDITIONING	40.00	
three surfaces	260.00		RECEMENT BRIDGE	50.00	
CROWN/ABUTMENT-PLASTIC WITH METAL	325.00	50.00	RECEMENT SPACE MAINTAINER	40.00	
CROWN/ABUTMENT-PORCELAIN JACKET	300.00	50.00			
CROWN/ABUTMENT-PORCELAIN WITH METAL	375.00	50.00	<u>ORAL SURGERY</u>		
FULL OR 3/4 CAST CROWN/ABUTMENT	300.00	50.00	SIMPLE EXTRACTION	55.00	
ACRYLIC JACKET	250.00		SURGICAL EXTRACTION	115.00	
LABIAL VENEER-lab processed	275.00		RETAINED ROOT	90.00	
STAINLESS STEEL CROWN-PRIMARY	100.00		IMPACTION-SOFT TISSUE	115.00	
PREFAB POST AND CORE	75.00		IMPACTION-PARTIAL BONY	185.00	
CAST POST & CORE	125.00		IMPACTION-COMPLETE BONY	225.00	
PIN RETENTION-PER TOOTH	25.00		BIOPSY OF ORAL TISSUE	135.00	
RECEMENT CROWN OR INLAY	30.00		ORAL ANTRAL FISTULA CLOSURE	200.00	
			ALVEOPLASTY PER QUAD	125.00	
<u>ENDODONTICS</u>			CYST REMOVAL < 1.25CM	150.00	
PULP CAP	10.00		CYST REMOVAL > 1.25CM.	190.00	
VITAL PULPOTOMY	60.00		INCISION & DRAINAGE	50.00	
ROOT CANAL THERAPY-1 CANAL	175.00	50.00	FRENULECTOMY	150.00	
ROOT CANAL THERAPY-2 CANALS	225.00	50.00	ROOT RESECTION	150.00	
ROOT CANAL THERAPY-3 CANALS	300.00	50.00	HEMISECTION	150.00	
APICOECTOMY	175.00	50.00			
APICO-MAXIMUM PER TOOTH	400.00	50.00	<u>ORTHODONTICS</u>		
RETROGRADE FILLING-per root	85.00		<u>DIAGNOSIS & INITIAL APPLIANCES</u>		
			removable appliance OR	225.00	
<u>ADJUNCTIVE SERVICES</u>			fixed appliance OR	600.00	
PALLIATIVE TREATMENT	30.00		HARMFUL HABIT APPLIANCE	225.00	
GENERAL ANESTHESIA-1ST 30 MIN	125.00		ACTIVE TREATMENT, per mth of treatment	75.00	
IV SEDATION- 1S 30 MIN	90.00		<i>maximum- 25 months</i>		
CONSULTATION BY SPECIALIST	50.00		PASSIVE TREATMENT, per 3 mths	75.00	
			<i>maximum- 9 mths</i>		
			POST-TREATMENT STABILIZATION DEVICE	100.00	

REV 9/15