DRYWALL TAPERS INSURANCE FUNDS
METRODENT 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	• Eligibility is determined according to the definition and requirements outlined in the Drywall Tapers Insurance Funds Summary Plan Description. • **Eligible dependents** 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	• January 1st through December 31st
PLAN MAXIMUM	• $3,000 annual maximum per covered individual, per calendar year excluding orthodontic services.
DEDUCTIBLE	• There is no annual deductible.
PLAN LIMITATIONS	• **Examination** – two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** maximum once every 36 months • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – to age 19, once per lifetime, per tooth • **Fluoride treatment** – to age 19, maximum one application per calendar year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $120 in a calendar year • **Orthodontic treatment –** $2,520 for eligible dependents to age 19 • **Specialist consultation –** one per year, includes 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
MISSING TOOTH CLAUSE	• Replacement of a tooth that was missing prior to the individual becoming eligible for dental benefits under the plan is not covered.
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 charges for deductibles, plan maximums or frequency limitations.
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. 117 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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DRYWALL TAPERS INSURANCE FUNDS
SCHEDULE OF ALLOWANCES

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	16.00
FULL MOUTH SERIES X-RAYS or PANORAMIC FILM	40.00
PA OR BW FIRST FILM	6.00
PA OR BW EACH FILM	5.00
OCCLUSAL FILM	11.00
POSTERIOR-ANTERIOR or LATERAL FILM	25.00
CEPHALOMETRIC FILM	40.00
EXTRAORAL or TEMPOROMANDIBULAR FILM	40.00
II-PREVENTIVE	
PROPHYLAXIS-Adult	33.00
PROPHYLAXIS-Child	25.00
FLUORIDE EXCL. PROPHY	16.00
SEALANT-to age 19	20.00
III-RESTORATIVE	
AMALGAM - 1 Surface	35.00
AMALGAM - 2 Surface	45.00
AMALGAM - 3 or more surfaces	55.00
AMALGAM - 4 or more surfaces	65.00
RESIN-1 SURFACE-Anterior or Posterior	45.00
RESIN-2 SURFACE-Anterior or Posterior	55.00
RESIN-3 SURFACE-Anterior or Posterior	65.00
INCISAL ANGLE - 4 plus surfaces including incisal	70.00
METALLIC INLAY-1 SRF	250.00
METALLIC INLAY-2 SRF	280.00
METALLIC INLAY-3 SRF	310.00
ONLAY	75.00
PORCELAIN INLAY-1 SRF	250.00
PORCELAIN INLAY-2 SRF	280.00
PORCELAIN INLAY-3 SRF	310.00
CROWN-PLASTIC TO METAL	350.00
CROWN-PORCELAIN	350.00
CROWN-PORCELAIN TO METAL	375.00
CROWN-FULL OR 3/4 CAST	350.00
CAST POST AND CORE	125.00
PREFAB POST AND CORE	100.00
PIN SUPPORT PER TOOTH	25.00
RECEMENT CROWN, INLAY OR BRIDGE	30.00
RECEMENT BRIDGE	50.00
PREFAB SS CROWN-primary teeth only	60.00
PORCELIAN LAMINATE	225.00
IV-ENDODONTICS	
PULP CAP-DIRECT	10.00
VITAL PULPOTOMY	70.00
ROOT CANAL THERAPY-1 CANAL	225.00
ROOT CANAL THERAPY-2 CANALS	350.00
ROOT CANAL THERAPY-3 CANALS	400.00
ROOT CANAL THERAPY-4+ CANALS	425.00
RETROGRADE FILLING	85.00
APICOECTOMY-first root	210.00
APICOECTOMY-max per tooth	420.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT-no other treatment	30.00
GENERAL ANESTHESIA/IV SEDATION	
Plan pays first 30 minutes only	210.00
SPECIALIST CONSULTATION	50.00

	MAXIMUM CHARGE
VI-PERIODONTICS	
GINGIVECTOMY-PER OUAD	225.00
OSSEOUS SURGERY-PER OUAD	350.00
FREE SOFT TISSUE GRAFTS-PER OUAD	250.00
OSSEOUS GRAFT-MAXIMUM PER OUAD	250.00
OSSEOUS GRAFT-SINGLE SITE	90.00
PEDICLE SOFT TISSUE GRAFT	250.00
CURETTAGE, SCALE\ROOT PLANING-per visit	50.00
PERIODONTAL MAINTENANCE PROCEDURE	50.00
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
BIOPSY OF ORAL TISSUE	75.00
ALVEOPLASTY-PER OUAD	150.00
REMOVAL OF CYST OR TUMOR-<1.25 CM	75.00
REMOVAL OF CYST OR TUMOR->1.25 CM	125.00
HEMISECTION/ROOT RESECTION	210.00
FRENULECTOMY	150.00
SURGICAL EXPOSURE FOR ORTHO	150.00
SURGICAL EXPOSURE TO AID ERUPTION	125.00
INCISION AND DRAINAGE-NO OTHER TREATMENT	50.00
REMOVAL OF RESIDUAL ROOTS	85.00
VIII-PROSTHODONTICS	
COMPLETE OR IMMEDIATE DENTURE	500.00
PARTIAL DENTURE-ACRYLIC BASE	285.00
PARTIAL DENTURE-CAST BASE	450.00
UNILATERAL PARTIAL DENTURE	250.00
DENTURE ADJUSTMENT	30.00
REPAIR COMP DENT BASE	90.00
REPAIR CAST FRAMEWORK	100.00
REPLC MISS/BRKN TTH-COM DENT	85.00
RELINE COMPLETE DENTURE-CHAIR	80.00
RELINE PARTIAL DENTURE-CHAIR	75.00
RELINE PARTIAL DENTURE-LABORATORY	130.00
RELINE COMPLETE DENTURE-LABORATORY	130.00
PONTIC-CAST METAL	325.00
PONTIC-PORCELAIN TO METAL	375.00
PONTIC-RESIN WITH METAL	350.00
ABUTMENT CROWN-PLASTIC WITH METAL	350.00
ABUTMENT CROWN-PORCELAIN WITH METAL	375.00
ABUTMENT CROWN-FULL CAST	350.00
REPLACE FACING	150.00
PRECISION ATTACHMENT	90.00
MARYLAND BRIDGE RETAINER	150.00
TISSUE CONDITIONING	40.00
IX-ORTHODONTICS	
MINOR TOOTH MOVEMENT/INTERCEPTIVE TX MAXIMUM CHARGE PER CASE	**780.00**
REMOVABLE APPLIANCE	270.00
FIXED APPLIANCE	270.00
ACTIVE TREATMENT, per month	65.00
COMPREHENSIVE TREATMENT MAXIMUM CHARGE PER CASE	**2520.00**
DIAGNOSIS & INITIAL APPLIANCE	400.00
ACTIVE TREATMENT, per month	65.00