BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST
BETHPAGE/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	• **Eligible dependents** include spouses, unmarried children who have not yet attained their 19th birthday or 25th birthday if attending an accredited school or college on a full-time basis.
ANNUAL MAXIMUM	• The calendar year maximum is $3000 per covered individual
ORTHODONTIC MAXIMUM	• Lifetime maximum is $2000 and is not subject to the annual maximum.
PLAN LIMITATIONS	• **Examination** – two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Cephalometric film** – one in 24 months • **Diagnostic casts** – 1 set per covered individual • **Replacement of prosthetics** – not more than once in five years • **Denture repairs** – limited to repairs or adjustments after 12 months from initial insertion • **Denture relines** – 12 months from initial insertion and then limited to one in 12 months • **Occlusal guard** – not more than once in 36 months • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored posterior teeth, to age 19, one application per tooth, per 36 months. • **Fluoride treatment** – to age 19, maximum two applications per year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $70 per visit • **Bone replacement grafts** – maximum per quadrant $325 • **Periodontal Maintenance –**two per calendar year, payable only after surgery • **Periodontal surgery –** charting and x-rays required; 1 in 36 consecutive months • **Amalgam restorations** – once per tooth in any 12 consecutive month period • **Specialist consultation –** one per year, no other treatment that same visit, 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 co-payment:** None • **Covered and reimbursable services, with co-payment:** Only established co-payment • **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. **Signature on file is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to: Self-Insured Dental Services, Dept. 118 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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IMPLANT AND IMPLANT RELATED SERVICES:

	Maximum Charge	Plan Pays	Member Pays
Endosteal Implant	$1,200.00	$600.00	$600.00
Subperiosteal Implant	$1,200.00	$600.00	$600.00
Transosseous Implant	$1,200.00	$600.00	$600.00
Prefabricated Abutment	$475.00	$237.50	$237.50
Custom Abutment	$475.00	$237.50	$237.50
Abutment Supported Porcelain Ceramic Crown	$675.00	$337.50	$337.50
Abutment Supported Porcelain/Metal Crown	$675.00	$337.50	$337.50
Abutment Supported Crown	$600.00	$300.00	$300.00
Abutment Supported Cast High Noble Metal Crown	$675.00	$337.50	$337.50
Abutment Supported Noble Metal Crown	$600.00	$300.00	$300.00
Implant Supported Porcelain Ceramic Crown	$975.00	$487.50	$487.50
Implant Supported Porcelain/High Noble Metal Crown	$975.00	$487.50	$487.50
Implant Supported High Noble Metal Crown	$975.00	$487.50	$487.50
Implant Removal, by report	$470.00	$235.00	$235.00

Radiographs of the entire arch are required for evaluation. There is a five-year frequency limitation for the replacement of prosthetic devices.

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

BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST

SCHEDULE OF ALLOWANCES

PROCEDURE	MAXIMUM CHARGE	PLAN PAYS	MEMBER PAYS
I-DIAGNOSTIC			
ORAL EXAM	22.00	22.00	0.00
X-RAYS (FULL MOUTH SERIES)	50.00	50.00	0.00
PERIAPICAL OR BITEWING (@ FILM)	5.00	5.00	0.00
OCCLUSAL FILM	15.00	15.00	0.00
EXTRAORAL FILM	25.00	25.00	0.00
TMJ FILM	45.00	45.00	0.00
PANORAMIC FILM	45.00	45.00	0.00
CEPHALOMETRIC FILM	45.00	45.00	0.00
II-PREVENTIVE			
PROPHYLAXIS-ADULT	42.00	42.00	0.00
PROPHYLAXIS-CHILD	25.00	25.00	0.00
FLUORIDE EXCL. PROPHY	25.00	25.00	0.00
SEALANT	22.00	22.00	0.00
SPACE MAINTAINER-UNILATERAL	150.00	150.00	0.00
III-RESTORATIVE			
AMALGAM - 1 SRF PRIMARY	45.00	45.00	0.00
AMALGAM - 2 SRF PRIMARY	55.00	55.00	0.00
AMALGAM - 3 SRF PRIMARY	65.00	65.00	0.00
AMALGAM - 4 SRF PRIMARY	70.00	70.00	0.00
AMALGAM - 1 SRF PERMANENT	45.00	45.00	0.00
AMALGAM - 2 SRF PERMANENT	55.00	55.00	0.00
AMALGAM - 3 SRF PERMANENT	70.00	70.00	0.00
AMALGAM - 4 SRF PERMANENT	80.00	80.00	0.00
RESIN-1 SURFACE, ANTERIOR	50.00	50.00	0.00
RESIN-2 SURFACE, ANTERIOR	65.00	65.00	0.00
RESIN-3 SURFACE, ANTERIOR	85.00	85.00	0.00
RESIN-4 SURFACE, INCLUDES INCISAL	110.00	110.00	0.00
RESIN-1 SURFACE, POSTERIOR	65.00	65.00	0.00
RESIN-2 SURFACE POSTERIOR	85.00	85.00	0.00
RESIN-3 SURFACE POSTERIOR	110.00	110.00	0.00
RESIN-4 SURFACE POSTERIOR	120.00	120.00	0.00
METALIC INLAY-1 SRF	245.00	245.00	0.00
METALIC INLAY-2 SRF	250.00	250.00	0.00
METALIC INLAY-3 SRF	375.00	375.00	0.00
PORCELAIN INLAY-1 SRF	250.00	250.00	0.00
PORCELAIN INLAY-2 SRF	275.00	275.00	0.00
PORCELAIN INLAY-3 SRF	325.00	325.00	0.00
CROWN PLASTIC	190.00	190.00	0.00
CROWN-RESIN WITH METAL	450.00	450.00	0.00
CROWN-PORCELAIN	450.00	450.00	0.00
CROWN-PORCELAIN WITH METAL	475.00	475.00	0.00
CROWN-3/4 OR FULL CAST	425.00	425.00	0.00
RECEMENT INLAY OR CROWN	40.00	40.00	0.00
PREFAB SS CROWN-PRIMARY	110.00	110.00	0.00
PIN RETENTION-PER TOOTH	25.00	25.00	0.00
CAST POST AND CORE	180.00	180.00	0.00
PREFAB POST AND CORE	150.00	150.00	0.00
LABIAL VENEER, LABRATORY	335.00	335.00	0.00
IV-ENDODONTICS			
PULP CAP-DIRECT	30.00	30.00	0.00
ROOT CANAL THERAPY-1 CANAL	350.00	350.00	0.00
ROOT CANAL THERAPY-2 CANALS	375.00	375.00	0.00
ROOT CANAL THERAPY-3 CANALS	425.00	425.00	0.00
ROOT CANAL THERAPY-4 CANALS	465.00	465.00	0.00
APICOECTOMY-PER ROOT	230.00	230.00	0.00
APICOECTOMY-maximum per tooth	310.00	310.00	0.00
RETROGRADE FILLING-PER ROOT	85.00	85.00	0.00
V-PERIODONTICS			
GINGIVECTOMY	200.00	200.00	0.00
OSSEOUS SURGERY-PER QUAD	450.00	450.00	0.00
OSSEOUS GRAFT-FIRST SITE	175.00	175.00	0.00
OSSEOUS GRAFT-ADDITIONAL SITE	250.00	250.00	0.00
PEDICLE SOFT TISSUE GRAFT	210.00	210.00	0.00
FREE SOFT TISSUE GRAFT	350.00	350.00	0.00
OCCLUSAL ADJUSTMENT COMPLETE	125.00	125.00	0.00
SCALE & ROOT PLANE-FULL MOUTH	90.00	90.00	0.00
SCALE & ROOT PLANE-PER VISIT	40.00	40.00	0.00
PERIODONTAL MAINTENANCE	60.00	60.00	0.00
VI-PROSTHODONTICS			
COMPLETE DENTURE	650.00	650.00	0.00
PARTIAL DENTURE-ACRYLIC BASE	575.00	575.00	0.00
PARTIAL DENTURE-CAST BASE	670.00	670.00	0.00
UNILATERAL PARTIAL DENTURE	300.00	300.00	0.00
REPAIR COMP DENT BASE	90.00	90.00	0.00
REPLC MISS/BRKN TTH-COM DENT	85.00	85.00	0.00
REPAIR PART ACRYLIC SADDLE/BASE	90.00	90.00	0.00
REPAIR CAST FRAMEWORK	100.00	100.00	0.00
REPAIR OR REPLACE BROKEN CLASP	85.00	85.00	0.00
REPLACE BROKEN TEETH- PER TOOTH	85.00	85.00	0.00
ADD TTH TO EXISTING PART DENT	85.00	85.00	0.00
ADD CLASP TO EXISTING PART DENT	100.00	100.00	0.00
RELINE COMPLETE DENTURE-CHAIR	140.00	140.00	0.00
RELINE PARTIAL DENTURE-CHAIR	85.00	85.00	0.00
RELINE COMPLETE DENTURE-LAB	150.00	150.00	0.00
RELINE PARTIAL DENTURE-LAB	145.00	145.00	0.00
TISSUE CONDITIONING	75.00	75.00	0.00
PONTIC-CAST METAL	350.00	350.00	0.00
PONTIC-PORCELAIN TO METAL	400.00	400.00	0.00
PONTIC-RESIN WITH METAL	400.00	400.00	0.00
METAL INLAY 2 SURFACES	280.00	280.00	0.00
METAL INLAY 3 OR MORE SURFACE	335.00	335.00	0.00
CAST METL RETNR-ACID ETCH BRIDGE	230.00	230.00	0.00
ABUTMENT-RESIN WITH METAL	400.00	400.00	0.00
ABUTMENT-PORCELAIN WITH METAL	425.00	425.00	0.00
ABUTMENT-FULL CAST	400.00	400.00	0.00
RECEMENT BRIDGE	40.00	40.00	0.00
REPLACE FACING	90.00	90.00	0.00
VII-ORAL SURGERY			
SIMPLE EXTRACTION	55.00	55.00	0.00
SURGICAL EXTRACTION	80.00	80.00	0.00
IMPACTION-SOFT TISSUE	115.00	115.00	0.00
IMPACTION-PARTIAL BONY	185.00	185.00	0.00
IMPACTION-COMPLETE BONY	225.00	225.00	0.00
ROOT RECOVERY	90.00	90.00	0.00
BIOPSY OF ORAL TISSUE	75.00	75.00	0.00
ALVEOPLASTY-WITH EXT, PER QUAD	65.00	65.00	0.00
CYST REMOVAL < 1.25CM	125.00	125.00	0.00
CYST REMOVAL > 1.25CM.	175.00	175.00	0.00
INCISION & DRAINAGE INTRAORAL	50.00	50.00	0.00
FRENULECTOMY	180.00	180.00	0.00
IX-ADJUNCTIVE SERVICES			
PALLIATIVE-EMERGENCY TRT	30.00	30.00	0.00
GENERAL ANESTHESIA-plan pays 1st 30 mi	150.00	150.00	0.00
CONSULTATION BY SPECIALIST	50.00	50.00	0.00
VIII-ORTHODONTIC SERVICES			
MINOR TOOTH GUIDANCE/INTERCEPT			
REMOVABLE APPLIANCE	270.00	270.00	0.00
FIXED APPLIANCE	300.00	300.00	0.00
ACTIVE TREATMENT, PER MONTH	60.00	60.00	0.00
MAXIMUM CHARGE PER CASE	**780.00**		
COMPREHENSIVE TREATMENT			
FIXED APPLIANCE	600.00	600.00	0.00
ACTIVE OR PASSIVE TRT, PER MONTH	60.00	60.00	0.00
PASSIVE TREATMENT, PER 3 MONTHS	60.00	60.00	0.00
POST-TREATMENT STABILIZATION DEVICI	120.00	120.00	0.00
MAXIMUM CHARGE PER CASE	**2600.00**		