

**PUBLISHERS'-NEWSPAPER AND MAIL DELIVERERS' WELFARE 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

- All covered Active participants of the PUBLISHERS'-NEWSPAPER AND MAIL DELIVERERS Welfare Fund Dental Plan.
- Members will have an identification card.
- Discounts are extended for spouses and unmarried children to age 23.
- If you have any questions regarding a member's eligibility please contact Self-Insured Dental Services at 516-396-5500.

PLAN OPERATION

- This is a **discount-fee-for-service** program. Since this is not an insurance plan, there are **no**:
 - **Claims to file**
 - **Annual maximums**
 - **Deductibles, or**
 - **Exclusions**

When a member does not have dental coverage – simply bill the member according to the MetroDENT Premier Schedule of Maximum Charges.

When a member has dental coverage (through their employer or spouse) and the insurance reimbursement is **less than** the maximum allowable charge, simply bill the member the difference between the plan payment and the MetroDENT Premier fee Schedule. When the insurance reimbursement is **higher than** the maximum allowable charge, simply charge the MetroDENT Premier Fee Schedule **only**.

PPO ADMINISTRATION

- The MetroDENT Premier PPO is administered by Self-Insured Dental Services. If you have any questions in regard to the operation of this plan, please contact:

**Self-Insured Dental Services
P.O. Box 9005
Lynbrook, NY 11563-9005
516 396-5500 / 718 204-7272
www.asonet.com**

For up to date detailed information, including member eligibility, please access our website at:
www.asonet.com

Rev 10/02

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

Dental Plan Administrators

SCHEDULE OF MAXIMUM CHARGES FOR PUBLISHERS'-NEWSPAPER AND MAIL DELIVERERS' WELFARE FUND

	Member Pays		Member Pays
I-DIAGNOSTIC		VI-PERIODONTICS	
ORAL EXAM	17.00	GINGIVECTOMY-PER QUADRANT	125.00
X-RAYS (FULL MOUTH SERIES)	40.00	OSSEOUS SURGERY-PER QUAD	400.00
P.A. OR B.W. EACH FILM	5.00	OSSEOUS GRAFT-SINGLE SITE	90.00
OCCLUSAL FILM	10.00	OSSEOUS GRAFT-PER QUADRANT	250.00
EXTRAORAL- (EACH FILM)	25.00	PEDICAL SOFT TISSUE GRAFT-PER QUADRANT	225.00
POSTERIOR-ANTERIOR, LATERAL or TMJ FILM	20.00	FREE SOFT TISSUE GRAFT- PER QUADRANT	275.00
PANORAMIC FILM	40.00	APICAL REPOSITIONING	175.00
CEPHALOMETRIC FILM/SIALOGRAPHY	40.00	CURETTAGE, SCALE/ROOT PLANING-PER VISIT	60.00
PULP VITALITY TEST	15.00	PERIO PROPHY	60.00
DIAGNOSTIC CASTS	25.00		
PALLIATIVE-EMERGENCY TRT	30.00	VII-PROSTHODONTICS	
CONSULTATION BY A SPECIALIST	50.00	COMPLETE DENTURE, IMMEDIATE OR PERMANENT	600.00
		PARTIAL DENTURE-ACRYLIC BASE	450.00
II-PREVENTIVE		PARTIAL DENTURE-CAST BASE	600.00
PROPHYLAXIS -ADULT	30.00	UNILATERAL PARTIAL DENTURE	200.00
PROPHYLAXIS-CHILD	25.00	DENTURE ADJUSTMENT	35.00
FLUORIDE EXCL PROPHY	10.00	REPAIR COMP DENT BASE	90.00
SEALANT-PER TOOTH	15.00	REPLC MISS/BRKN TTH-COM DENT	85.00
SPACE MAINTAINER	150.00	REPAIR PART ACRYLIC SADDLE/BASE	90.00
		REPAIR CAST FRAMEWORK	100.00
III-RESTORATIVE		REPAIR OR REPLACE BROKEN CLASP	85.00
PRIMARY OR PERMANENT AMALGAM - 1 SURFAC	45.00	ADD TTH TO EXISTING PART DENT	85.00
PRIMARY OR PERMANENT AMALGAM - 2 SURFAC	55.00	ADD CLASP TO EXISTING PART DENT	85.00
PRIMARY OR PERMANENT AMALGAM - 3 SURFAC	60.00	REBASING OR RELINE DENTURE	
PRIMARY OR PERMANENT AMALGAM - 4+ SURFAC	70.00	PARTIAL DENTURE, LAB	100.00
ANTERIOR OR POSTERIOR COMPOSITE RESIN -	50.00	PARTIAL DENTURE, CHAIR	75.00
ANTERIOR OR POSTERIOR COMPOSITE RESIN -	60.00	COMPLETE DENTURE, LAB	125.00
ANTERIOR OR POSTERIOR COMPOSITE RESIN -	70.00	COMPLETE DENTURE, CHAIR	95.00
ANTERIOR OR POSTERIOR COMPOSITE RESIN -	80.00	TISSUE CONDITIONING	40.00
FULL FACED BONDING	100.00	PONTIC-CAST METAL	350.00
COMPOSITE RESIN-INCISAL ANGLE	80.00	PONTIC-PORCELAIN TO METAL	425.00
METALLIC INLAY-1 SRF	200.00	PONTIC-RESIN WITH METAL	375.00
METALLIC INLAY-2 SRF	230.00	ABUTMENT-CAST METL RETAINER	230.00
METALLIC INLAY-3 SRF	260.00	ABUTMENT-RESIN WITH METAL	375.00
METALLIC ONLAY-IN ADDITION TO INLAY	70.00	ABUTMENT-PORCELAIN FUSED TO METAL	425.00
PORCELAIN INLAY-1 SRF	200.00	ABUTMENT-FULL CAST	350.00
PORCELAIN INLAY-2 SRF	230.00	PRECISION ATTACHMENT	125.00
PORCELAIN INLAY-3 SRF	260.00	REPLACE FACING	100.00
ACRYLIC JACKET-LAB PROC	175.00		
CROWN-PORCELAIN	350.00	VIII-ORAL SURGERY	
CROWN-PLASTIC WITH METAL	375.00	SINGLE EXTRACTION	50.00
CROWN-PORCELAIN WITH METAL	425.00	SURGICAL EXTRACTION	75.00
CROWN-FULL CAST	350.00	ROOT RECOVERY	100.00
CROWN-3/4 CAST	350.00	IMPACTION-SOFT TISSUE	115.00
PREFAB SS CROWN-PRIMARY	100.00	IMPACTION-PARTIAL BONY	185.00
RECEMENT-INLAY OR CROWN	30.00	IMPACTION-COMPLETE BONY	225.00
RECEMENT-BRIDGE OR SPACE MAINTAINER	40.00	SURGICAL EXPOSURE IMP/UNERUP	80.00
PIN RETENTION-PER TOOTH	25.00	SURGICAL EXPOSURE IMP/UNERUP-ORTHO	160.00
PREFAB POST AND CORE	100.00	BIOPSY OF ORAL TISSUE	95.00
CAST POST AND CORE	125.00	ALVEOPLASTY-PER QUAD	150.00
LABIAL VENEER, LAB	250.00	CYST REMOVAL <1.25 CM	75.00
		CYST REMOVAL >1.25 CM	125.00
IV-ENDODONTICS		INCISION & DRAINAGE INTRAORAL	50.00
PULP CAP	10.00	FRENULECTOMY	100.00
VITAL PULPOTOMY	60.00	GENERAL ANESTHESIA-1ST 30 MINUTES	125.00
ROOT CANAL THERAPY-1 CANAL	275.00	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUT	40.00
ROOT CANAL THERAPY-2 CANALS	325.00		
ROOT CANAL THERAPY-3 CANALS	400.00	IX-ORTHODONTICS	
ROOT CANAL THERAPY-4 CANALS	475.00	MINOR TOOTH MOVEMENT/INTERCEPTIVE TRT	
APICOECTOMY-PER ROOT	130.00	REMOVABLE APPLIANCE	270.00
APICOECTOMY-MAX PER TOOTH	260.00	FIXED APPLIANCE	400.00
RETROGRADE FILLING	85.00	ACTIVE TREATMENT, PER MONTH	60.00
ROOT RESECTION/HEMISECTION	150.00	MAXIMUM CHARGE PER CASE	780.00
		COMPREHENSIVE TREATMENT	
		REMOVABLE & HARMFUL HABIT APPLIANCE	270.00
		FIXED APPLIANCE	480.00
		ACTIVE TREATMENT, PER MONTH	70.00
		PASSIVE TREATMENT, PER 3 MONTHS	70.00
		POST TREATMENT STABILIZATION DEVICE	120.00
		MAXIMUM CHARGE PER CASE	2800.00