TEAMSTERS LOCAL 1205 WELFARE FUND
METRODENT PPO NETWORK PLAN B
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** – full or partial - not more than once in four years • **Replacement of Fixed Bridge or Crown** – 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 co-payment:** no surcharge permitted • **Covered and reimbursable services, with co-payment:** only established co-payment • **Covered but not reimbursable service, no co-payment:** scheduled allowance • **Covered but not reimbursable service, with co-payment:** scheduled allowance plus established co-payment • **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. 151 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

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

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MetroDENT Dental Network
SCHEDULE OF MAXIMUM CHARGES

I-DIAGNOSTIC	Plan Pays	Member Pays
ORAL EXAM	13.00	2.00
OCCLUSAL FILM	10.00	0.00
EXTRAORAL- (EACH FILM)	25.00	0.00
PA OR BITEWING X-RAYS-(PER FILM)	3.00	0.00
POSTERIOR-ANTERIOR, LATERAL TMJ	25.00	0.00
FULL MOUTH SERIES or PANORAMIC	30.00	5.00
CEPHALOMETRIC FILM	34.00	0.00
PALLIATIVE-EMERGENCY TRT	25.00	5.00
SPECIALIST CONSULTATION	40.00	10.00
II-PREVENTIVE		
PROPHYLAXIS-ADULT	20.00	2.00
PROPHYLAXIS-CHILD(to age 13)	20.00	2.00
FLUORIDE EXCL. PROPHY	10.00	0.00
SEALANT-PER TOOTH	15.00	0.00
SPACE MAINTAINER	100.00	0.00
III-RESTORATIVE		
AMALGAM - 1 SRF	20.00	5.00
AMALGAM - 2 SRF	30.00	5.00
AMALGAM - 3 SRF	40.00	5.00
AMALGAM - 4+ SRF	45.00	5.00
RESIN-1 SURFACE	37.00	5.00
RESIN-2 SURFACE	41.00	5.00
RESIN-3 OR MORE SURFACES	45.00	5.00
RESIN-4 SURF INCL INCISAL ANGLE	45.00	5.00
PIN RETENTION-PER TOOTH	15.00	0.00
METALLIC INLAY-1SRF	110.00	40.00
METALLIC INLAY-2 SRF	150.00	40.00
METALLIC INLAY-3 SRF	190.00	40.00
PORCELAIN INLAY - 1 SRF	150.00	0.00
PORCELAIN INLAY - 2 SRF	180.00	0.00
PORCELAIN INLAY - 3 SRF	210.00	0.00
CROWN-ACRYLIC JACKET	110.00	0.00
CROWN-ACRYLIC WITH METAL	285.00	40.00
CROWN-PORCELAIN JACKET	285.00	40.00
CROWN-PORCELAIN WITH METAL	335.00	40.00
GOLD FULL CAST CROWN	260.00	40.00
CROWN-3/4 CAST	260.00	40.00
PONTIC-CAST METAL	260.00	40.00
PONTIC-PORCELAIN TO METAL	335.00	40.00
PONTIC-RESIN WITH METAL	285.00	40.00
PONTIC-PLASTIC WITH METAL	285.00	40.00
CAST METL RETNR-ACID ETCH BRIDGE	110.00	40.00
RECEMENT BRIDGE/SP MAINTAINER	30.00	0.00
RECEMENT INLAY or CROWN	20.00	0.00
PREFAB SS CROWN-PRIMARY	75.00	0.00
CAST POST AND CORE	95.00	0.00
PREFAB POST AND CORE	75.00	0.00
LABIAL VENEER	235.00	40.00
IV-PERIODONTICS		
GINGIVECTOMY-PER QUADRANT	90.00	10.00
OSSEOUS SURGERY-PER QUAD	310.00	40.00
OSSEOUS GRAFT-PER SITE	80.00	10.00
OSSEOUS GRAFT-PER QUAD	150.00	100.00
PEDICLE SOFT TISSUE GRAFT	100.00	100.00
FREE SOFT TISSUE GRAFT	150.00	100.00
CURET, SCALE/ROOT PLAN-PER VISIT	35.00	5.00
PERIODONTAL MAINTENANCE PROC	55.00	0.00
OCCLUSAL ADJUSTMENT	35.00	5.00

V-ENDODONTICS	Plan Pays	Member Pays
PULP CAP	10.00	0.00
VITAL PULPOTOMY	40.00	0.00
ROOT CANAL THERAPY-1 CANAL	235.00	40.00
ROOT CANAL THERAPY-2 CANALS	285.00	40.00
ROOT CANAL THERAPY-3 CANALS	385.00	40.00
APICOECTOMY-PER ROOT	130.00	0.00
APICOECTOMY-MAX PER TTH	260.00	0.00
RETROGRADE FILLING	60.00	0.00
ROOT RESECTION/HEMISECTION	105.00	0.00
VI-PROSTHODONTICS		
COMPLETE/IMMEDIATE DENTURE	450.00	40.00
PARTIAL DENTURE-ACRYLIC BASE	285.00	40.00
PARTIAL DENTURE-CAST BASE	430.00	40.00
UNILATERAL PARTIAL DENTURE	110.00	40.00
DENTURE ADJUSTMENT	25.00	0.00
REPAIR COMP DENT BASE	65.00	0.00
REPLC MISS/BRKN TTH-COM DENT	65.00	0.00
REPAIR PART ACRYLIC SADDLE/BASE	65.00	0.00
REPAIR CAST FRAMEWORK	95.00	0.00
REPAIR OR REPLACE BROKEN CLASP	75.00	0.00
REPLACE BROKEN TEETH-PER TTH	65.00	0.00
ADD TTH TO EXISTING PART DENT	75.00	0.00
ADD CLASP TO EXISTING PART DENT	75.00	0.00
RELINE COMPLETE DENTURE-CHAIR	75.00	0.00
RELINE PARTIAL DENTURE-CHAIR	60.00	0.00
RELINE COMPLETE DENTURE-LAB	125.00	0.00
RELINE PARTIAL DENTURE-LAB	100.00	0.00
REPLACE FACING	100.00	0.00
TISSUE CONDITIONING	40.00	0.00
VII-ORAL SURGERY		
SIMPLE EXTRACTION	25.00	5.00
SURGICAL EXTRACTION	55.00	5.00
IMPACTION-SOFT TISSUE	80.00	10.00
IMPACTION-PARTIAL BONY	130.00	10.00
IMPACTION-COMPLETE BONY	175.00	10.00
EXPOSURE OF TTH-AID ERUPTION	80.00	0.00
EXPOSURE OF TTH-FOR ORTHO	160.00	0.00
ROOT RECOVERY	85.00	5.00
ALVEOPLASTY-PER QUAD	125.00	0.00
BIOPSY OF ORAL TISSUE	75.00	0.00
CYST REMOVAL < 1.25CM	45.00	0.00
CYST REMOVAL > 1.25CM	90.00	0.00
FRENULECTOMY	95.00	0.00
INCISION AND DRAINAGE	50.00	0.00
GENERAL ANESTHESIA-1st 30mins.	50.00	40.00
VIII-ORTHODONTIC SERVICES		
DIAGNOSIS & INITIAL APPLIANCE	200.00	200.00
ACTIVE TREATMENT, PER MONTH	65.00	0.00
PASSIVE TREATMENT, PER 3 MTHS	65.00	0.00
REMOVABLE APPLIANCE	225.00	0.00
HARMFUL HABIT APPLIANCE	225.00	0.00
POST-TREAT STAB DEVICE	100.00	0.00

Rev 1/11