ORGANIZATION OF STAFF ANALYSTS WELFARE FUND
OSA/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	• All employees eligible for benefits under the Organization of Staff Analysts Welfare Fund. • **Eligible Dependents** Include the lawful spouse and each dependent child from birth until the age of 26.
PLAN YEAR	• July 1 st through June 30 th.
ANNUAL MAXIMUM	• $5,000 per individual each plan year (July 1 st – June 30 th)
DEDUCTIBLE	• The deductible is waived for participating providers.
WAITING PERIOD	• There is a two year waiting period for the replacement of missing teeth.
PLAN LIMITATIONS	• **Examination** – one in six months • **Prophylaxis** – one in six months, included in payment for periodontal procedures • **X-rays –** $75 annual maximum • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – not payable on same day as other therapy • **Sealant** – permanent molars, to age 16, lifetime maximum of two applications per tooth • **Fluoride Treatment** – once a year to age 16 • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – paid on a per visit basis • **Orthodontic treatment –** $4000 lifetime maximum. Orthodontic treatment is not subject to the annual maximum. • **Specialist consultation –** one per specialty in a plan year • **Denture Reline –** 6 months after delivery, once in a three year period • **Cone Beam Scans -** once per 24 months
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-payments • **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. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : Self-Insured Dental Services, Dept 22 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 (800) 537-1238 Rev 7/23

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IMPLANT AND IMPLANT RELATED SERVICES:

	Maximum Charge
Endosteal Implant	$1,200.00
Subperiosteal Implant	$1,200.00
Transosseous Implant	$1,200.00
Prefabricated Abutment	$500.00
Custom Abutment	$600.00
Abutment Supported Porcelain Ceramic Crown	$750.00
Abutment Supported Porcelain/Metal Crown	$750.00
Abutment Supported Crown	$650.00
Abutment Supported Cast High Noble Metal Crown	$750.00
Abutment Supported Noble Metal Crown	$650.00
Implant Supported Porcelain Ceramic Crown	$1100.00
Implant Supported Porcelain/High Noble Metal Crown	$1100.00
Implant Supported High Noble Metal Crown	$1100.00

EFFECTIVE: 7/2017

MetroDENT-ORGANIZATION OF STAFF ANALYSTS DENTAL PLAN

SCHEDULE OF ALLOWANCES

	Maximum Allowance
I-DIAGNOSTIC	
INITIAL ORAL EXAM	29.00
PERIODIC ORAL EXAM	18.00
FIRST PERIAPICAL X-RAY	12.00
2 BITEWING X-RAYS	16.00
4 BITEWING X-RAYS	25.00
EACH ADDITIONAL PERIAPICAL X-RAY	8.00
OCCLUSAL FILM	15.00
POSTERIOR-ANTERIOR, LATERAL	44.00
PANORAMIC	46.00
FULL MOUTH SERIES	58.00
CEPHALOMETRIC FILM	46.00
DIAGNOSTIC CASTS	46.00
CONE BEAM SCAN	250.00
II-PREVENTIVE	
PROPHYLAXIS-adult	45.00
PROPHYLAXIS-child up to age 16	31.00
FLUORIDE EXCL PROPHY	16.00
SEALANT-PER TOOTH	25.00
SPACE MAINTAINER	144.00
III-RESTORATIVE	
SEDATIVE FILLING	39.00
AMALGAM - 1 SRF-permanent tooth	47.00
AMALGAM - 2 SRF-permanent tooth	60.00
AMALGAM - 3 SRF-permanent tooth	74.00
AMALGAM - 4+ SRF-permanent tooth	89.00
RESIN-1 SRF-anterior	59.00
RESIN-2 SRF-anterior	81.00
RESIN-3 SRF-anterior	104.00
RESIN-4 SRF & INCISAL ANGLE	106.00
RESIN-1 SRF-posterior	59.00
RESIN-2 SRF-posterior	81.00
RESIN-3 OR MORE SRF-posterior	104.00
METALLIC INLAY-1 SRF	150.00
METALLIC INLAY-2 SRF	190.00
METALLIC INLAY-3 SRF	403.00
METALLIC-ONLAY	40.00
PORCELAIN INLAY-1 SRF	170.00
PORCELAIN INLAY-2 SRF	380.00
PORCELAIN INLAY-3 SRF	430.00
CROWN-PLASTIC	205.00
CROWN-RESIN WITH METAL	431.00
CROWN-PORCELAIN FUSED TO BASE METAL	404.00
CROWN-PORCELAIN	431.00
CROWN-PORCELAIN WITH METAL	460.00
CROWN-3/4 or FULL CAST	403.00
PONTIC-RESIN WITH METAL	431.00
PONTIC-PORCELAIN TO METAL	460.00
PONTIC-CAST METAL	403.00
CAST METL RETNR-ACID ETCH BRIDGE	200.00
RECEMENT BRIDGE	56.00
RECEMENT INLAY	39.00
RECEMENT CROWN	38.00
PREFAB SS CROWN-PRIMARY	109.00
PIN RETENTION-PER TOOTH	23.00
CAST POST AND CORE	161.00
PREFAB POST AND CORE	138.00
LABIAL VENEER	390.00
V-ENDODONTICS	
PULP CAP	29.00
VITAL PULPOTOMY	72.00
ROOT CANAL THERAPY-anterior	318.00
ROOT CANAL THERAPY-bicuspid	366.00
ROOT CANAL THERAPY-molar	474.00
RETREATMENT ROOT CANAL-anterior	650.00
RETREATMENT ROOT CANAL-bicuspid	750.00
RETREATMENT ROOT CANAL-molar	950.00
APICOECTOMY-PER ROOT	390.00
APICOECTOMY-MAX PER TOOTH	690.00
RETROGRADE FILLING	96.00
IX-ADJUNCTIVE SERVICES	
PALLIATIVE-EMERGENCY TRT	39.00
CONSULTATION BY A SPECIALIST	50.00
GENERAL ANESTHESIA	143.00
ANALGESIA	25.00

	Maximum Allowance
IV-PERIODONTICS	
GINGIVECTOMY-PER QUADRANT	186.00
OSSEOUS SURGERY-PER QUAD	510.00
OSSEOUS GRAFT-PER SITE	168.00
OSSEOUS GRAFT-PER QUAD	259.00
PEDICAL SOFT TISSUE GRAFT	362.00
FREE SOFT TISSUE GRAFT	289.00
GUIDED TISSUE REGEN-NONRESORB	100.00
GUID TISS REGEN-RESORB BARRIER/SITE	250.00
BONE GRAFT-RIDGE PRESERVATION	300.00
OCCLUSAL ADJUSTMENT-LIMITED	35.00
OCCLUSAL ADJUSTMENT-COMPLETE	65.00
CURETTAGE, SCALE\ROOT PLANING-VISIT	90.00
CURETTAGE, SCALE\ROOT PLANING-FULL MOUTH	210.00
PERIODONTAL MAINTENANCE PROCEDURE	72.00
PERIODONTAL APPLIANCE-BRUXISM	160.00
VI-PROSTHODONTICS	
COMPLETE OR IMMEDIATE DENTURE	604.00
PARTIAL DENTURE-ACRYLIC BASE	472.00
PARTIAL DENTURE-CAST BASE	702.00
UNILATERAL PARTIAL DENTURE	351.00
DENTURE ADJUSTMENT	31.00
FIXED PARTIAL DENT SECTIONING	100.00
REPAIR COMP DENT BASE	69.00
REPLC MISS/BRKN TTH-COM DENT	65.00
REPAIR PART ACRYLIC SADDLE/BASE	75.00
REPAIR CAST FRAMEWORK	95.00
REPAIR OR REPLACE BROKEN CLASP	86.00
REPLACE BROKEN TEETH- PER TOOTH	60.00
ADD CLASP TO EXISTING PART DENT	86.00
ADD TOOTH TO EXISTING PART DENT	75.00
RELINE COMPLETE DENTURE-CHAIR	115.00
RELINE PARTIAL DENTURE-CHAIR	109.00
RELINE COMPLETE DENTURE-LAB	190.00
RELINE PARTIAL DENTURE-LAB	190.00
TISSUE CONDITIONING	40.00
REPLACE FACING	106.00
PRECISION ATTACHMENT	100.00
ENDOSTEAL IMPLANT	1,200.00
CUSTOM ABUTMENT	600.00
PREFABRICATED ABUTMENT	500.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	60.00
SIMPLE EXTRACTION-each additional tooth	58.00
SURGICAL EXTRACTION	109.00
IMPACTION-SOFT TISSUE	138.00
IMPACTION-PARTIAL BONY	184.00
IMPACTION-COMPLETE BONY	230.00
SURGICAL EXPOSURE-ORTHO	247.00
SURGICAL EXPOSURE-AID ERUPTION	161.00
ROOT RECOVERY	115.00
ALVEOPLASTY-PER QUAD	125.00
INCISION & DRAINAGE-no other treatment that visit	76.00
BIOPSY OF SOFT TISSUE	122.00
BIOPSY OF HARD TISSUE	156.00
CYST REMOVAL	176.00
FRENULECTOMY	177.00
ROOT RESECTION/HEMISECTION	216.00
SINUS AUGMENTATION	2,000.00
VIII-ORTHODONTIC SERVICES	
DIAGNOSIS, INCLUDING MODELS	121.00
MINOR TOOTH GUIDANCE/INTERCEPT	
REMOVABLE APPLIANCE	225.00
FIXED APPLIANCE	250.00
ACTIVE TREATMENT, PER MONTH	50.00
COMPREHENSIVE TREATMENT	
REMOVABLE APPLIANCE	225.00
HARMFUL HABIT APPLIANCE	225.00
FIXED APPLIANCE	690.00
ACTIVE TREATMENT, PER MONTH	92.00
PASSIVE TREATMENT, PER 3 MONTHS	60.00
POST-TREATMENT STABILIZATION DEVICE	135.00

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