

**MOVING PICTURE MACHINE OPERATORS UNION OF GREATER NEW YORK
LOCAL 306 PROJECTIONIST DIVISION
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	<ul style="list-style-type: none"> Your eligibility and the eligibility of your dependents is defined in your Moving Picture Machine Operators Union Of Greater New York (MPMOU) Local 306 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	<ul style="list-style-type: none"> January 1 st through December 31 st
PLAN MAXIMUM	<ul style="list-style-type: none"> \$1,250 per covered individual in a calendar year
PLAN LIMITATIONS	<ul style="list-style-type: none"> Examination – two in a calendar year Prophylaxis – two in a calendar year X-rays – panoramic or full mouth series – one in thirty six months Palliative treatment – no other treatment rendered that same visit Fluoride treatment – to age 19, one treatment per year Replacement of crowns, bridges and dentures – not more than once in five years Periodontal Treatment – maximum \$200 per calendar year General anesthesia – First 30 minutes only Incision & drainage – no other treatment that visit Orthodontic treatment – \$2,520 for eligible dependents, to age 19 including interceptive treatment, comprehensive orthodontic therapy and post-treatment retention. The Orthodontic Benefit is not subject to the annual maximum Specialist consultation – one per calendar year
PRE-TREATMENT REVIEW	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 and established co-payement Non-covered services: Your usual charge for that service
COORDINATION OF BENEFITS	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 85. 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

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

Dental Plan Administrators

MOVING PICTURE MACHINE OPERATORS UNION OF GREATER NEW YORK LOCAL 306 PROJECTIONIST DIVISION

SCHEDULE OF ALLOWANCES

	PLAN PAYS	MEMBER CO-PAY		PLAN PAYS	MEMBER CO-PAY
I-DIAGNOSTIC					
ORAL EXAM	17.00		OSSEOUS GRAFT-PER QUAD	250.00	
PERIAPICAL (EACH FILM)	5.00		SCALE & ROOT PLANE-FULL MOUTH	50.00	
OCCLUSAL FILM	10.00		SCALE & ROOT PLANE-PER VISIT	50.00	
EXTRAORAL- (EACH FILM)	25.00		PERIO MAINTENANCE PROCEDURE	50.00	
BITEWING (EACH FILM)	5.00		PEDICLE SOFT TISSUE GRAFT-PER QUAD	250.00	
X-RAY (TMJ FILM)	20.00		FREE SOFT TISSUE GRAFT PER QUAD	250.00	
PANORAMIC OR CEPHALOMETRIC FILM	40.00		VII-PROSTHODONTICS		
POSTERIOR-ANTERIOR, LATERAL FILM	20.00		COMPLETE OR IMMEDIATE DENTURE	500.00	100.00
SIALOGRAPHY	40.00		PARTIAL DENTURE-CAST BASE	500.00	100.00
PALLIATIVE TREATMENT, relief of pain	30.00		PARTIAL DENTURE-ACRYLIC	325.00	100.00
II-PREVENTIVE					
PROPHYLAXIS-ADULT	30.00		UNILATERAL PARTIAL DENTURE	200.00	
PROPHYLAXIS-CHILD	25.00		REPAIR DENTURE BASE-complete or partial	90.00	
FLUORIDE EXCL. PROPHY	10.00		REPAIR CAST FRAMEWORK	100.00	
SEALANT-PER TOOTH	15.00		REPLACE BROKEN TEETH- PER TOOTH	85.00	
SPACE MAINTAINER	150.00		ADD TTH TO EXISTING PART DENT	85.00	
RECEMENT SPACE MAINTAINER	40.00		REPAIR OR REPLACE BROKEN CLASP	85.00	
III-RESTORATIVE					
AMALGAM - 1 SURFACE	45.00		RELINE COMPLETE DENTURE-CHAIR	75.00	
AMALGAM - 2 SURFACES	55.00		RELINE COMPLETE DENTURE-LAB	125.00	
AMALGAM - 3 SURFACES	60.00		RELINE PARTIAL DENTURE-CHAIR	75.00	
AMALGAM - 4 OR MORE SURFACES	65.00		RELINE PARTIAL DENTURE-LAB	100.00	
RESIN - 1 SURFACE	50.00		PONTIC-PORCELAIN TO METAL	325.00	100.00
RESIN - 2 SURFACES	60.00		PONTIC-FULL CAST	250.00	100.00
RESIN - 3 or more SURFACES	70.00		PONTIC-RESIN TO METAL	275.00	100.00
RESIN - INCISAL EDGE	80.00		MARYLAND BRIDGE RETAINER	130.00	100.00
METALLIC OR PORCELAIN INLAY - 1 SRF	150.00	50.00	PRECISION ATTACHMENT	125.00	
METALLIC OR PORCELAIN INLAY - 2 SRF	180.00	50.00	ABUTMENT-PORCELAIN WITH METAL	325.00	100.00
METALLIC OR PORCELAIN INLAY - 3 SRF	210.00	50.00	ABUTMENT-RESIN WITH METAL	275.00	100.00
METALLIC ONLAY-IN ADDITION TO INLAY	70.00		ABUTMENT-FULL CAST AND 3/4 CAST	250.00	100.00
CROWN - ACRYLIC JACKET	175.00		RECEMNT BRIDGE	40.00	
CROWN-RESIN WITH METAL	275.00	100.00	DENTURE ADJUSTMENT	35.00	
CROWN-PORCELAIN JACKET	250.00	100.00	REPLACE FACING	100.00	
CROWN-PORCELAIN WITH METAL	325.00	100.00	TISSUE CONDITIONING	40.00	
CROWN-FULL or 3/4 CAST	250.00	100.00	VIII-ORAL SURGERY		
RECEMENT CROWN or INLAY	30.00		SIMPLE EXTRACTION	50.00	
PREFAB SS CROWN-PRIMARY	75.00		SURGICAL EXTRACTION	75.00	
SEDATIVE FILLING	13.00		IMPACTION-SOFT TISSUE	115.00	
PIN RETENTION-PER TOOTH	25.00		IMPACTION-PARTIAL BONY	135.00	50.00
CAST POST AND CORE IN LAB	125.00		IMPACTION-COMLETE BONY	175.00	50.00
PREFAB POST AND CORE	75.00		ROOT RECOVERY	90.00	
PORCELAIN LAMINATE VENEER, LAB	200.00	50.00	SURGICAL EXPOS IMP/UNERUP	80.00	
IV-ENDODONTICS					
PULP CAP-DIRECT	10.00		SURGICAL EXPOS IMP/UNERUP-ORTHO	160.00	
VITAL PULPOTOMY	60.00		BIOPSY OF ORAL TISSUE	75.00	
ROOT CANAL THERAPY-1 CANAL	175.00	50.00	ALVEOPLASTY PER QUAD	125.00	
ROOT CANAL THERAPY-2 CANALS	225.00	50.00	CYST REMOVAL < 1.25CM.	75.00	
ROOT CANAL THERAPY-3 CANALS	300.00	50.00	CYST REMOVAL > 1.25CM.	125.00	
ROOT CANAL THERAPY-4 CANALS	350.00	50.00	INCISION & DRAINAGE INTRAORAL	50.00	
APICOECTOMY-1st ROOT	130.00		FRENULECTOMY	95.00	
APICOECTOMY, MAX PER TOOTH	260.00		IX-ORTHODONTIC SERVICES		
ROOT RESECTION/HEMISECTION	150.00		MINOR TOOTH MOVEMENT/INTERCEPTIVE		
RETROGRADE ROOT FILLING	85.00		MAXIMUM CHARGE PER CASE		
V-ADJUNCTIVE SERVICES					
PALLIATIVE-EMERGENCY TRT	30.00		REMOVABLE APPLIANCE	270.00	
GENERAL ANESTHESIA	125.00		FIXED APPLIANCE	300.00	
CONSULTATION BY SPECIALIST	50.00		ACTIVE TREATMENT, PER MONTH	60.00	
VI-PERIODONTICS					
GINGIVECTOMY	100.00		COMPREHENSIVE TREATMENT		
OSSEOUS SURGERY-PER QUAD	250.00	100.00	MAXIMUM CHARGE PER CASE		
OSSEOUS GRAFT-SINGLE SITE	90.00		DIAGNOSIS & INITIAL APPLIANCE	480.00	
			ACTIVE TREATMENT, PER MONTH	60.00	
			PASSIVE TREATMENT, PER 3 MONTHS	60.00	
			HARMFUL HABIT APPLIANCE	270.00	
			POST-TREATMENT STABILIZATION DEVICE	120.00	
			REMOVABLE APPLIANCE	270.00	