

**PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST 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	<ul style="list-style-type: none"> All Active and Retiree members covered under the Port Chester Teachers Association Welfare Trust Fund 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	<ul style="list-style-type: none"> January 1 st through December 31 st
ANNUAL MAXIMUM	<ul style="list-style-type: none"> \$3,000 maximum per family
PLAN LIMITATIONS	<ul style="list-style-type: none"> Examination – two per calendar year Prophylaxis – two per calendar year Panoramic or full mouth series – once every 36 months Replacement of prosthetics – once every five years Fluoride treatment – two per calendar year, up to age 19 Root Scaling, curettage, bite correction; any combination, including prophylaxis – \$240 per calendar year Periodontal Surgery – once every 24 months Specialist Consultation – one per calendar year Orthodontic treatment – 18 months active treatment, \$1,000 lifetime maximum per covered individual
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: None Covered but not reimbursable services: Schedule allowance 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 benefits from the other plan must first be applied to reduce or eliminate co-payments, deductibles, or charges levied due to maximums. PCTA follows the gender rule when coordination benefits for dependent children.
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. 28 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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Self-Insured Dental Services / Administrative Services Only, Inc.**Dental Plan Administrators**

PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST FUND

SCHEDULE OF DENTAL ALLOWANCES

	Plan Pays		Plan Pays
<u>I-DIAGNOSTIC</u>		<u>V-PERIODONTICS</u>	
ORAL EXAM	50.00	GINGIVECTOMY-PER QUADRANT	210.00
PERIAPICAL X-RAY-FIRST FILM	15.00	CURETTAGE, SCALE/ROOT PLANING-FULL MC	90.00
PERIAPICAL X-RAY-EACH ADDITIONAL FILM	10.00	CURETTAGE, SCALE/ROOT PLANING PER VIS	70.00
BITEWING X-RAY-FIRST FILM	15.00	OSSEOUS GRAFT-PER QUAD	500.00
BITEWING X-RAY-EACH ADDITIONAL FILM	25.00	OSSEOUS SURGERY-PER QUAD	175.00
OCCUSAL FILM	15.00	OSSEOUS GRAFT-PER SITE	350.00
FULL MOUTH SERIES	50.00	FREE SOFT TISSUE GRAFT	144.00
PANORAMIC FILM	45.00	PERIODONTAL MAINTENANCE	95.00
<u>II-PREVENTIVE</u>		<u>VI-PROSTHODONTICS</u>	
PROPHYLAXIS-ADULT	85.00	COMPLETE DENTURE	600.00
PROPHYLAXIS-CHILD	70.00	IMMEDIATE DENTURE	600.00
FLUORIDE EXCL PROPHY	25.00	PARTIAL DENTURE-ACRYLIC BASE	700.00
<u>III-RESTORATIVE</u>		PARTIAL DENTURE-CAST BASE	320.00
AMALGAM - 1 SRF	90.00	UNILATERAL PARTIAL DENTURE	25.00
AMALGAM - 2 SRF	100.00	DENTURE ADJUSTMENT	41.00
AMALGAM - 3 SRF	115.00	REPAIR COMP DENT BASE	41.00
AMALGAM - 4+ SRF	125.00	REPAIR PART ACRYLIC SADDLE/BASE	75.00
RESIN-1 SURFACE	95.00	REPAIR CAST FRAMEWORK	100.00
RESIN-2 SURFACE	105.00	REPAIR OR REPLACE BROKEN CLASP	100.00
RESIN-3 OR MORE SURFACES	125.00	ADD TTH TO EXISTING PART DENT	81.00
RESIN-INCISAL ANGLE	150.00	RELINE COMPLETE DENTURE-CHAIR	58.00
METALLIC INLAY-1 SRF	205.00	RELINE PARTIAL DENTURE-CHAIR	150.00
METALLIC INLAY-2 SRF	305.00	RELINE COMPLETE DENTURE-LAB	145.00
METALLIC INLAY-3 SRF	330.00	RELINE PARTIAL DENTURE-LAB	75.00
PORCELAIN INLAY-1 SRF	205.00	TISSUE CONDITIONING	
PORCELAIN INLAY-2 SRF	305.00	<u>VII-ORAL SURGERY</u>	
PORCELAIN INLAY-3 SRF	330.00	SIMPLE EXTRACTION	120.00
CROWN-PLASTIC	190.00	EXTRACTION-ROOT REMOVAL	105.00
CROWN-RESIN WITH METAL	365.00	SURGICAL EXTRACTION	150.00
CROWN-PORCELAIN	350.00	IMPACTION-SOFT TISSUE	180.00
CROWN-PORCELAIN WITH METAL	500.00	IMPACTION-PARTIAL BONY	225.00
CROWN-FULL CAST	460.00	IMPACTION-COMPLETE BONY	240.00
CROWN-3/4 CAST	300.00	SURGICAL EXPOSURE(for ortho)	155.00
PONTIC-CAST METAL	380.00	SURGICAL EXPOSURE(to aid eruption)	155.00
PONTIC-PORCELAIN TO METAL	500.00	ALVEOPLASTY-PER QUAD	85.00
PONTIC-RESIN TO METAL	350.00	INCISION & DRAINAGE	50.00
CAST METL RETNR-ACID ETCH BRIDGE	300.00	BIOPSY OF SOFT TISSUE	115.00
RECEMENT BRIDGE	30.00	BIOPSY OF HARD TISSUE	135.00
RECEMENT CROWN	40.00	CYST REMOVAL < 1.25CM	170.00
RECEMENT INLAY	18.00	CYST REMOVAL > 1.25CM.	200.00
CAST POST AND CORE	180.00	FRENULECTOMY	145.00
PREFAB POST AND CORE	180.00	ROOT RESECTION/HEMISECTION	100.00
<u>IV-ENDODONTICS</u>		<u>VIII-ORTHODONTIC SERVICES</u>	
PULP CAP	30.00	FIXED APPLIANCE	350.00
VITAL PULPOTOMY	70.00	ACTIVE TREATMENT, PER MONTH	65.00
APICOECTOMY-FIRST ROOT	250.00	PASSIVE TREATMENT, PER 3 MONTHS	65.00
APICOECTOMY-PER TOOTH	450.00	<u>IX-ADJUNCTIVE SERVICES</u>	
RETROGRADE FILLING	95.00	PALLIATIVE-EMERGENCY TRT	40.00
ROOT CANAL THERAPY-1 CANAL	400.00	CONSULTATION BY A SPECIALIST	60.00
ROOT CANAL THERAPY-2 CANALS	425.00	GENERAL ANESTHESIA	130.00
ROOT CANAL THERAPY-3 CANALS	475.00	ANESTHESIA-IV SEDATION	130.00

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