VALLEY CENTRAL TEACHERS ASSOCIATION BENEFIT FUND
METRODENT PREMIER MAXIMUM 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	• Benefits are available to employees of the Valley Central School District No. 1 working part time (at least 20 hours per week) or a full time employee as so designated by Valley Central Teachers Association Benefit Fund and contributions are made to the Fund. **Eligible dependents** include spouses, unmarried children who have not yet attained their 23rd birthday
PLAN YEAR	• July 1 – June 30
ANNUAL MAXIMUM	• $2,000 in a plan year
ORTHODONTICS	• $2,000 Lifetime maximum per individual
PLAN LIMITATIONS	• **Examination** – two per plan year. • **Prophylaxis** – two per plan year. • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored posterior teeth, to age 16, lifetime maximum two applications per tooth. • **Fluoride treatment** – to age 16, maximum one applications per year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – max 2 quadrants per visit, maximum $400 per calendar year • **Periodontal Maintenance –**subject to the periodontal maximum, payable only after surgery • **Periodontal surgery –** charting and x-rays required; 1 in 36 consecutive months • **Orthodontic treatment – $2,000 Lifetime maximum**-maximum 24 months of active treatment • **Implants –**maximum of one implant per calendar year,maximum of four implants per lifetime. • **Specialist consultation –** one per plan year, no other treatment that same visit, 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:** None • **Covered and reimbursable services, with co-payment:** Only established co-payment • **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. **Signature on file is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to: Self-Insured Dental Services, Dept. 30 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

ADMINISTRATIVE SERVICES ONLY (ASO.INC) /SELF INSURED DENTAL SERVICES (SIDS) **DENTAL PLAN ADMINISTRATORS**

VALLEY CENTRAL TEACHERS ASSOCIATION BENEFIT

SCHEDULE OF MAXIMUM CHARGES

	PLAN PAYS	MEMBER COPAY
I-DIAGNOSTIC		
ORAL EXAM -	45.00	
PERIAPICAL or BITEWING X-RAY (FIRST FILM)	12.00	
PERIAPICALor BITEWING EACH ADDITONAL	10.00	
CEPHALOMETRIC FILM	70.00	
POSTERIOR ANTERIOR LATERAL -FILM	70.00	
OCCLUSAL FILM STERIOR-ANTERIOR, LATERAL FILM	70.00	
PANORAMIC FILM	85.00	
FULL MOUTH X-RAY	110.00	
CONE BEAM CT	300.00	
II-PREVENTIVE		
PROPHYLAXIS-ADULT	80.00	
PROPHYLAXIS-CHILD(to age 14)	65.00	
SEALANT	30.00	
FLUORIDE	25.00	
SPACE MAINTAINER	225.00	
III-RESTORATIVE		
AMALGAM - 1 SRF PERMANENT/ PRIMARY	95.00	
AMALGAM - 2 SRF PERMANENT/ PRIMARY	110.00	
AMALGAM - 3 SRF PERMANENT/ PRIMARY	120.00	
AMALGAM - 4+ SRF PERMANENT/ PRIMARY	150.00	
RESIN-1 SURFACE, ANTERIOR	115.00	
RESIN-2 SURFACE, ANTERIOR	125.00	
RESIN-3 OR MORE SURFACE, ANTERIOR	150.00	
RESIN-1 SURFACE, POSTERIOR	120.00	
RESIN-2 SURFACE, POSTERIOR	130.00	
RESIN-3 SURFACE, POSTERIOR	155.00	
RESIN-4 OR MORE SURFACE , POSTERIOR	175.00	
RESIN-INCISAL ANGLE	170.00	
PORCELAIN INLAY-1 SRF	350.00	100.00
PORCELAIN INLAY-2 SRF	450.00	100.00
PORCELAIN INLAY-3 SRF	500.00	100.00
CROWN-RESIN (LABORATORY)	275.00	100.00
CROWN-RESIN WITH METAL	550.00	100.00
CROWN-PORCELAIN JACKET	600.00	100.00
CROWN-PORCELAIN WITH METAL	650.00	100.00
CROWN FULL CAST	500.00	100.00
RECEMENT CROWN	75.00	
REFAB SS CROWN-PRIMARY	150.00	
PIN RETENTION-PER TOOTH	35.00	
CAST POST AND CORE	215.00	
PREFAB POST AND CORE	150.00	
LABIAL VENEER	525.00	100.00
IV-ENDODONTICS		
PULP CAP	30.00	
VITAL PULPOTOMY	130.00	
ROOT CANAL THERAPY-anterior	550.00	
ROOT CANAL THERAPY-bicuspid	650.00	
ROOT CANAL THERAPY-Molar	750.00	
RETREATMENT -anterior	700.00	
RETREATMENT-bicuspid	800.00	
RETREATMENT -Molar	900.00	
APICOECTOMY, first root	450.00	
APICOECTOMY, maximum per tooth	850.00	
RETROGRADE FILLING PER ROOT	150.00	
ROOT RESECTION/HEMISECTION	150.00	
V-ADJUNCTIVE SERVICES		
PALLIATIVE-EMERGENCY TRT	50.00	
GENERAL ANESTHESIA/IV SEDATION PER 15 MIN MAX 30	125.00	
CONSULTATION BY A SPECIALIST	80.00	
OCCLUSAL GUARD	300.00	

	PLAN PAYS	MEMBER COPAY
VI-PERIODONTICS		
GINGIVECTOMY-PER QUADRANT	300.00	
OSSEOUS SURGERY-PER QUAD	700.00	
OSSEOUS GRAFT- SINGLE SITE	225.00	
CURETTAGE, SCALE\ROOT PER QUAD	100.00	
PERIODONTAL MAINTENANCE PROCEDURE	90.00	
FREE-SOFT TISSUE GRAFT	375.00	
LOCALIZED DELIV. CHEMOTHERAPEUTIC AGENTS	75.00	
VII-PROSTHODONTICS		
COMPLETE DENTURE	850.00	100.00
IMMEDIATE DENTURE	850.00	100.00
PARTIAL DENTURE-ACRYLIC BASE-W/C	600.00	100.00
PARTIAL DENTURE-CAST BASE	875.00	100.00
UNILATERAL PARTIAL DENTURE	425.00	100.00
DENTURE ADJUSTMENT	65.00	
REPAIR COMP DENT BASE	110.00	
REPLC MISS/BRKN TTH-COM DENT	100.00	
REPAIR PART ACRYLIC SADDLE/BASE	100.00	
REPAIR CAST FRAMEWORK	90.00	
REPAIR OR REPLACE BROKEN CLASP	75.00	
REPLACE BROKEN TEETH- PER TOOTH	100.00	
ADD TTH TO EXISTING PART DENT	100.00	
ADD CLASP TO EXISTING PART DENT	100.00	
RELINE COMPLETE DENTURE-CHAIR	175.00	
RELINE PARTIAL DENTURE-CHAIR	150.00	
RELINE COMPLETE DENTURE-LAB	225.00	
RELINE PARTIAL DENTURE-LAB	200.00	
TISSUE CONDITIONING	40.00	
PONTIC-CAST METAL	500.00	100.00
PONTIC-PORCELAIN TO METAL	625.00	100.00
PONTIC-RESIN WITH METAL	500.00	100.00
MARYLAND BRIDGE RETAINER	475.00	
ABUTMENT -PORCELAIN WITH METAL	675.00	100.00
ABUTMENT FULL CAST	600.00	100.00
RECEMENT BRIDGE	100.00	
REPLACE BROKEN FACING	150.00	
VIII-ORAL SURGERY		
SIMPLE EXTRACTION	100.00	
SURGICAL EXTRACTION	190.00	
IMPACTION-SOFT TISSUE	230.00	
IMPACTION-PARTIAL BONY	325.00	
IMPACTION-COMPLETE BONY	400.00	
CORONECTOMY	400.00	
EXPOSURE UNERUPTED/ORTHO PURPOSES	275.00	
INCISION & DRAINAGE	150.00	
BIOPSY OF ORAL TISSUE	150.00	
ALVEOPLASTY-PER QUAD	150.00	
CYST REMOVAL < 1.25CM	225.00	
CYST REMOVAL > 1.25CM.	350.00	
FRENULECTOMY	200.00	
BONE GRAFT	350.00	
IX-IMPLANTOLOGY		
ENDOSTEAL IMPLANT	700.00	700.00
CUSTOM/PREFAB ABUTMENT	300.00	300.00
ABUTMENT SUPPORTED CROWN	750.00	100.00
IMPLANT SUPPORTED CROWN	300.00	300.00
	900.00	100.00
X-ORTHODONTIC TREATMENT		
DIAG. & INITIAL INSERTION	1000.00	
ACTIVE TREATMENT-PER MONTH	150.00	
PASSIVE TREATMENT- PER 3 MONTHS	150.00	
APPLIANCE REMOVAL AND RETAINER CONSTRUCTION	150.00	

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