MANAGEMENT LABOR WELFARE FUND, LOCAL 1730 I.L.A.
LOCAL 1730 I.L.A. 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 members covered under the Management-Labor Welfare Fund, Local 1730 I.L. A. are eligible for dental benefits • **Eligible dependents** include spouses, unmarried children to age 19 (coverage is extended until the 26th birthday for unmarried dependent children attending school full-time)
PLAN YEAR	• January 1 through December 31
PLAN MAXIMUM	• $2,000 maximum per covered individual in a calendar year
DEDUCTIBLE	• There is no deductible
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **X-rays –** maximum payment $60 in a calendar year • **Replacement of crowns, bridge, dentures** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 17, one per year • **Sealant –** permanent posterior teeth to age 17, lifetime maximum-2 applications • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $150 in a calendar year • **Orthodontic treatment –** $1,850 lifetime maximum for eligible dependents; subject to the annual maximum, maximum 24 months of active treatment • **Specialist Consultation –** one in a calendar year, includes 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:** None • **Covered but not reimbursable services:** Schedule allowance • **Non-covered services:** Your usual charge for that service
COORDINATION OF BENEFITS	• This plan does not coordinate benefits if a dependent is eligible for benefits under another group dental plan.
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 40. 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 3/11

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

MANAGEMENT LABOR WELFARE FUND, LOCAL 1730 I.L.A.
Schedule Of Allowances

DIAGNOSTIC & PREVENTIVE	**MAXIMUM CHARGE**
ORAL EXAM	25.00
FULL MOUTH SERIES	45.00
PANORAMIC X-RAY	30.00
PERIAPICAL OR BITEWING-EACH	4.00
OCCLUSAL FILM	12.00
EXTRAORAL ,ANTER-POST,TMJ,CEPHAL	25.00
PROPHYLAXIS	45.00
CHILD PROPHY	20.00
FLUORIDE TREATMENT	15.00
SPACE MAINTAINER	100.00
SEALANT	15.00

RESTORATIVE	**MAXIMUM CHARGE**
AMALGAM-one surface-primary	20.00
AMALGAM-two surface-primary	30.00
AMALGAM-three pr more surface-primary	40.00
AMALGAM-one surface-permanent	45.00
AMALGAM-two surface-permanent	55.00
AMALGAM-three surface-permanent	65.00
AMALGAM-four or more surface-permanent	75.00
COMPOSITE RESIN-one surface	50.00
COMPOSITE RESIN-two surface	60.00
COMPOSITE RESIN-three surface	70.00
COMPOSITE RESIN-4 + incisal	80.00
PIN RETENTION	15.00
METALLIC INLAY/ONLAY-one surface	100.00
METALLIC INLAY/ONLAY-two surface	135.00
METALLIC INLAY/ONLAY-three or more	160.00
CAST POST & CORE	90.00
PRE-FAB POST & CORE	65.00
LAMINATE VENEER	275.00

CROWNS AND BRIDGES	**MAXIMUM CHARGE**
CROWN-acrylic jacket (lab processed)	150.00
CROWN-stainless steel (primary tooth)	75.00
CROWN-porcelain jacket	300.00
CROWN-plastic with metal	325.00
CROWN-porcelain with metal	375.00
CROWN-full cast or 3/4 cast	325.00
PONTIC-full cast	300.00
PONTIC-plastic with metal	300.00
PONTIC-porcelain with metal	350.00
RECEMENT-crown or inlay	20.00
RECEMENT-bridge	35.00

ENDODONTICS	**MAXIMUM CHARGE**
PULP CAP	10.00
VITAL PULPOTOMY	65.00
ROOT THERAPY-one canal	225.00
ROOT THERAPY-two canals	275.00
ROOT THERAPY-three or more canals	375.00
APICOECTOMY-first root	125.00
APICOECTOMY-max per tooth	250.00
RETROGRADE ROOT FILLING	50.00
ROOT RESECTION/HEMISECTION	110.00

PERIODONTICS	**MAXIMUM CHARGE**
PERIODONTAL TREATMENT	
root scaling, subgingival curettage	
bite correction, including prophy	
per visit	35.00
entire mouth	75.00
PERIODONTAL SURGERY-per quad	
gingivectomy,gingivoplasty,soft tissue graft,	
osseous graft, vestibulo. or any combination	150.00
osseous surgery per quad	350.00
osseous graft per quadrant	250.00
osseous graft single site	50.00

ORAL SURGERY	**MAXIMUM CHARGE**
ROUTINE EXTRACTION	50.00
SURGICAL EXTRACTION	
erupted tooth	75.00
retained root	75.00
impaction-soft tissue	90.00
impaction-partial bony	120.00
impaction-complete bony	200.00
SURGICAL EXPOSURE OF IMPACTED	
OR UNERUPTED TOOTH	
to aid eruption	75.00
ALVEOLOPLASTY-per quad	120.00
REMOVAL of CYST or TUMOR	50.00
FRENULECTOMY	75.00
BIOPSY	25.00

DENTURES	**MAXIMUM CHARGE**
IMMEDIATE OR PERMANENT DENTURE	500.00
PARTIAL DENTURE-acrylic or cast metal	500.00
REPAIR BROKEN DENTURE BASE	75.00
REPLACE TOOTH IN DENTURE	75.00
REPLACE BROKEN FACING	75.00
REPAIR BROKEN CAST FRAMEWORK	75.00
ADD OR REPLACE CLASP	75.00
REATTACH UNDAMAGED CLASP	75.00
ADD TOOTH TO EXISTING PARTIAL	75.00
RELINE COMPLETE DENTURE-CHAIR	100.00
RELINE PARTIAL DENTURE-CHAIR	80.00
RELINE COMPLETE DENTURE-LAB	125.00
RELINE PARTIAL DENTURE-LAB	100.00

ORTHODONTICS	**MAXIMUM CHARGE**
INITIAL ORTHODONTIC APPLIANCE	
full treatment-fixed appliance	500.00
ACTIVE TREATMENT-per month	50.00
PASSIVE TREATMENT-per 3 months	50.00
RETAINER	125.00
FIXED APPLIANCE-HARMFUL HABIT	125.00

ADJUNCTIVE SERVICES	**MAXIMUM CHARGE**
PALLIATIVE TREATMENT	25.00
SPECIALIST CONSULTATION	50.00
GENERAL ANESTHESIA	125.00