LOCAL 153 HEALTH FUND
LOCAL 153 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	• Individuals who are in Covered Employment under the provisions of a collective bargaining agreement with the **Local 153 Health Fund.** Retirees meeting eligibility requirements are also covered • **Eligible dependents**: Include the spouse and, unmarried dependent children who have not yet reached their 19th birthday. Coverage is extended until the 26th birthday for unmarried dependent children attending school full-time. Unmarried children incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation, or physical handicap; will continue to be eligible.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $2,000 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 • **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 15, once per calendar year • **Sealant –** eligible dependents only, one application per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – Maximum $120 in a calendar year • **Orthodontic treatment –** $1,450 lifetime maximum; not subject to annual maximum
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 and customary charges and benefits from the other plan must first be applied to reduce to eliminate any charges incurred due to co-payments, plan maximums or frequency limitations.
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\ • Claims are processed by SIDS. Claim forms must first be sent to Local 153 for eligibility verification. • Mail claims to : Self-Insured Dental Services, Dept. 45 P.O. Box 9005 Lynbrook, NY 11563 • File claims electronically: **PAYOR ID: CX076**

For up to date detailed information 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

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

LOCAL 153
SCHEDULE OF ALLOWANCES

DIAGNOSTIC & PREVENTIVE	MAXIMUM CHARGE
ORAL EXAM	13.00
FULL MOUTH SERIES	30.00
PANORAMIC X-RAY	30.00
PERIAPICAL X-RAY	3.00
BITEWING X-RAY	3.00
OCCLUSAL FILM	10.00
EXTRAORAL OR TMJ FILM	25.00
CEPHALOMETRIC FILM	25.00
PROPHYLAXIS - ADULT	20.00
PROPHYLAXIS - CHILD	13.00
FLOURIDE EXCL PROPHY	10.00
SEALANT-PER TTH	15.00
SPACE MAINTAINER	100.00
PALLIATIVE TREATMENT	12.00
RESTORATIVE	
SILVER AMALGAM FILLINGS	
PRIMARY	
one surface	20.00
two surfaces	27.00
three or more surfaces	32.00
PERMANENT	
one surface	25.00
two surfaces	35.00
three or more surfaces	45.00
COMPOSITE RESIN FILLINGS	
one surface	30.00
two surfaces	40.00
three or more surfaces	40.00
BONDED RESIN, INCISAL ANGLE	50.00
PIN RETENTION	15.00
METALLIC INLAY or ONLAY	
one surface	150.00
two surface	190.00
three or more surfaces	230.00
CAST POST & CORE	95.00
PRE-FAB POST & CORE	65.00
LAMINATE VENEER	215.00
CROWNS	
acrylic jacket (lab processed)	150.00
stainless steel (primary tooth)	75.00
porcelain jacket	325.00
plastic with metal	325.00
porcelain with metal	375.00
full cast	300.00
3/4 cast	300.00
RECEMENTATION	
crown or inlay	20.00
bridge or space maintainer	30.00
ENDODONTICS	
PULP CAP	10.00
VITAL PULPOTOMY	40.00
ROOT THERAPY	
one canal	175.00
two canals	250.00
three canals	350.00
four canals	400.00
APICOECTOMY, FIRST ROOT	150.00
APICOECTOMY, MAX PER TOOTH	300.00
RETROGRADE ROOT FILLING	50.00

*** INCLUDES A $250 MEMBER CO-PAYMENT**

PERIODONTICS	MAXIMUM CHARGE
PERIODONTAL TREATMENT	
root scaling, subgingival curettage	
bite correction, including prophy	
per visit	30.00
full mouth	60.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00
PERIODONTAL SURGERY-per quad	
gingivectomy or gingivoplasty,	
soft tissue graft, vestibuloplasty,	
any combination	125.00
osseous surgery	300.00
OSSEOUS GRAFT-single site	65.00
OSSEOUS GRAFT-multiple site	200.00
ORAL SURGERY	
ROUTINE EXTRACTION	45.00
SURGICAL EXTRACTION	
erupted tooth	60.00
retained root	60.00
impaction-soft tissue	60.00
impaction-partial bony	125.00
impaction-complete bony	185.00
SURGICAL EXPOSURE OF IMPACTED	
OR UNERUPTED TOOTH	60.00
CYST REMOVAL < 1.25	30.00
CYST REMOVAL > 1.25	50.00
FRENULECTOMY	65.00
ALVEOLOPLASTY-per quad	75.00
INCISE AND DRAIN	20.00
BIOPSY	65.00
ROOT RESECTION	70.00
HEMISECTION	85.00
PROSTHODONTICS	
COMPLETE DENTURE	
immediate or permanent	400.00
PARTIAL DENTURE-ACRYLIC BASE	225.00
unilateral-one tooth	225.00
PARTIAL DENTURE-CAST CHROME	400.00
BRIDGE PONTICS	
full cast	300.00
plastic with metal	325.00
porcelain with metal	375.00
MARYLAND BRIDGE RETAINER	200.00
PRECISION ATTACHMENT	75.00
DENTURE REPAIRS	
broken denture base	65.00
repair partial acrylic saddle/base	75.00
replace miss/brkn tooth in denture	65.00
replace broken facing	25.00
add or replace clasp	65.00
repair cast framework	65.00
DENTURE RELINE	
complete denture - office	75.00
partial denture - office	60.00
complete denture - lab	125.00
partial denture - lab	100.00
ORTHODONTICS	
INITIAL ORTHODONTIC APPLIANCE	
full treatment-fixed appliance	**625.00 ***
ACTIVE TREATMENT-per month	50.00
PASSIVE TREATMENT-per 3 months	50.00
RETAINER APPLIANCE	125.00
HARMFUL HABIT APPLIANCE	125.00