PAINTING INDUSTRY INSURANCE FUND D.C. 9
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	• **Eligible dependents**: Include 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	• January 1 st through December 31 st
PLAN MAXIMUM	• $2,000 per covered individual calendar year
DEDUCTIBLE	• There is no annual 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, bridges and dentures** – not more than once in 5 years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, two applications per year • **Sealant –** to age 19, one application in lifetime of tooth • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – • one scaling root planning per visit. maximum $180 in a calendar year • **Denture Adjustment –** one per year after first year of insertion • **Osseous surgery or graft –** $250 maximum per quadrant once in 36 months • **Orthodontic treatment –** to the age of 19. 24 active monthly treatments and 9 passive treatments payable per 3 months. Participating MetroDENT Premier Orthodontists limit their fees to the MetroDENT Premier scheduled allowances for the services rendered. • **Specialist Consultation –** one per calendar year, 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 plus established co-payment • **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 the 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. There is a 12 month claim submission limit.** • 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 : ASO, Dept 55. 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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MetroDENT PREMIER DENTAL NETWORK
Painting Industry Insurance Fund D.C. 9
Schedule of Maximum Charges

I-DIAGNOSTIC	PLAN PAYS	MEMBER CO-PAY
ORAL EXAM	17.00	0.00
PERIAPICAL X-RAY (EACH FILM)	5.00	0.00
OCCLUSAL FILM	10.00	0.00
EXTRAORAL- (EACH FILM)	25.00	0.00
BITEWING-(EACH FILM)	5.00	0.00
POSTERIOR-ANTERIOR, LATERAL, TMJ	25.00	0.00
FULL MOUTH SERIES or PANORAMIC	40.00	0.00
CEPHALOMETRIC FILM	30.00	0.00
SALIOGRAPHY	40.00	0.00
II-PREVENTIVE		
PROPHYLAXIS-ADULT	30.00	0.00
PROPHYLAXIS-CHILD(to age 14)	25.00	0.00
FLUORIDE EXCL. PROPHY	10.00	0.00
SEALANT-PER TOOTH	15.00	0.00
SPACE MAINTAINER	150.00	0.00
III-RESTORATIVE		
AMALGAM - 1 SURFACE	45.00	0.00
AMALGAM - 2 SURFACES	55.00	0.00
AMALGAM - 3 SURFACES	60.00	0.00
AMALGAM - 4 or more SURFACES	65.00	0.00
RESIN - 1 SURFACE	52.00	0.00
RESIN - 2 SURFACES	60.00	0.00
RESIN - 3 or more SURFACES	70.00	0.00
RESIN-INCISAL ANGLE	80.00	0.00
PIN RETENTION-PER TOOTH	25.00	0.00
METALLIC/PORCELAIN INLAY-1 SRF	150.00	50.00
METALLIC/PORCELAIN INLAY-2 SRF	180.00	50.00
METALLIC/PORCELAIN INLAY-3 SRF	210.00	50.00
ONLAY-METALLIC	70.00	0.00
CROWN-ACRYLIC JACKET	175.00	0.00
CROWN-ACRYLIC WITH METAL	300.00	75.00
CROWN-PORCELAIN JACKET	275.00	75.00
CROWN-PORCELAIN WITH METAL	350.00	75.00
GOLD FULL CAST CROWN	275.00	75.00
CROWN-3/4 CAST	275.00	75.00
PONTIC-CAST METAL	275.00	75.00
PONTIC-PORCELAIN TO METAL	350.00	75.00
PONTIC-RESIN WITH METAL	300.00	75.00
CAST METL RETNR-ACID ETCH BRIDGE	155.00	75.00
RECEMENT BRIDGE or SPACE MAINTAINER	40.00	0.00
RECEMENT INLAY or CROWN	30.00	0.00
PREFAB SS CROWN-PRIMARY	75.00	0.00
CAST POST AND CORE	125.00	0.00
PREFAB POST AND CORE	75.00	0.00
LABIAL VENEER	225.00	50.00
IV-PERIODONTICS		
GINGIVECTOMY-PER QUADRANT	60.00	50.00
OSSEOUS SURGERY-PER QUAD	275.00	75.00
OSSEOUS GRAFT-PER SITE	90.00	0.00
OSSEOUS GRAFT-PER QUAD	50.00	0.00
CURETTAGE, SCALE\ROOT PLANING-VISIT	60.00	0.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00	0.00
PEDICLE SOFT TISSUE GRAFT PER QUAD	250.00	0.00
FREE SOFT TISSUE GRAFT PER QUAD	200.00	0.00
IX-ADJUNCTIVE SERVICES		
SPECIALIST CONSULTATION	50.00	0.00
GENERAL ANESTHESIA-1st 30 minutes	125.00	0.00
PALLIATIVE-EMERGENCY TRT	30.00	0.00

V-ENDODONTICS	PLAN PAYS	MEMBER CO-PAY
PULP CAP	10.00	0.00
VITAL PULPOTOMY	60.00	0.00
ROOT CANAL THERAPY-Anterior	175.00	50.00
ROOT CANAL THERAPY-Biscuspid	225.00	50.00
ROOT CANAL THERAPY-Molar	300.00	50.00
APICOECTOMY-PER ROOT	150.00	0.00
APICOECTOMY-MAX PER TTH	300.00	0.00
RETROGRADE FILLING	85.00	0.00
ROOT RESECTION/HEMISECTION	150.00	0.00
VI-PROSTHODONTICS		
COMPLETE DENTURE	550.00	50.00
IMMEDIATE DENTURE	550.00	50.00
PARTIAL DENTURE-ACRYLIC BASE	375.00	50.00
PARTIAL DENTURE-CAST BASE	550.00	50.00
UNILATERAL PARTIAL DENTURE	200.00	0.00
REPAIR COMP DENT BASE	90.00	0.00
REPLC MISS/BRKN TTH-COM DENT	85.00	0.00
REPAIR PART ACRYLIC SADDLE/BASE	90.00	0.00
REPAIR CAST FRAMEWORK	100.00	0.00
REPAIR OR REPLACE BROKEN CLASP	85.00	0.00
REPLACE BROKEN TEETH- PER TOOTH	85.00	0.00
ADD TTH TO EXISTING PART DENT	85.00	0.00
ADD CLASP TO EXISTING PART DENT	85.00	0.00
RELINE COMPLETE DENTURE-CHAIR	80.00	0.00
RELINE PARTIAL DENTURE-CHAIR	75.00	0.00
RELINE COMPLETE DENTURE-LAB	125.00	0.00
RELINE PARTIAL DENTURE-LAB	100.00	0.00
REPLACE FACING	100.00	0.00
PRECISION ATTACHMENT	125.00	0.00
TISSUE CONDITIONING	40.00	0.00
DENTURE ADJUSTMENT	35.00	0.00
VII-ORAL SURGERY		
SIMPLE EXTRACTION	50.00	0.00
SURGICAL EXTRACTION	75.00	0.00
IMPACTION-SOFT TISSUE	115.00	0.00
IMPACTION-PARTIAL BONY	185.00	0.00
IMPACTION-COMPLETE BONY	225.00	0.00
ROOT RECOVERY	90.00	0.00
SURGICAL EXPOS IMP/UNERUP	80.00	0.00
SURGICAL EXPOS IMP/UNERUP-ORTHO	160.00	0.00
ALVEOPLASTY-PER QUAD	125.00	0.00
INCISION & DRAINAGE	50.00	0.00
BIOPSY OF ORAL TISSUE	75.00	0.00
CYST REMOVAL < 1.25CM	75.00	0.00
CYST REMOVAL > 1.25CM.	125.00	0.00
FRENULECTOMY	95.00	0.00
VIII-ORTHODONTIC SERVICES		
MINOR TOOTH MOVEMENT/INTERCEPTIVE TRT		
MAXIMUM CHARGE PER CASE	**780.00**	0.00
REMOVABLE APPLIANCE	270.00	0.00
FIXED APPLIANCE	300.00	0.00
MONTHLY TREATMENT	60.00	0.00
COMPREHENSIVE TREATMENT		
MAXIMUM CHARGE PER CASE	**2520.00**	
DIAGNOSIS & INITIAL APPLIANCE	405.00	75.00
ACTIVE TREATMENT, PER MONTH	60.00	0.00
PASSIVE TREATMENT, PER 3 MONTHS- 3 MAX	60.00	0.00
HARMFUL HABIT APPLIANCE	270.00	0.00
POST-TREATMENT STABILIZATION DEVICE	120.00	0.00

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