ASSISTANT DEPUTY WARDENS/ DEPUTY WARDENS ASSOCIATION
ADW/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	• Active members of the ASSISTANT DEPUTY WARDENS/DEPUTY WARDENS ASSOCIATION, for whom the Security Benefits Fund receives a contribution under the Collective Bargaining Agreement with the City of New York, are eligible for these benefits. Eligible Retirees are also covered. • **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	• Annual maximum $7,000 per member, $5,000 per spouse and dependent children in a calendar year
DEDUCTIBLE	• There is no annual deductible
PLAN LIMITATIONS	• **Examination** –three in a calendar year • **Prophylaxis** – four in a calendar year • **X-rays** – $125.00 per calendar year-any combination • **Cone Beam CT Scans** - once in a five year period • **Replacement of crowns, bridges and dentures** – not more than once in 5 years • **Crown Build-up/Post & Core** - not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, 2 in a calendar year • **Sealant –** to age 19, unrestored permanent posterior teeth, lifetime max 1 application per tooth • **Root Scaling, bite correction; any combination, including prophylaxis** – payable per visit • **Periodontal Grafts/ Guided tissue regeneration** - max 2 per quadrant, once in 36 months • **Orthodontic treatment –** $3,600 lifetime max, max 24 months active treatment, to age 19 • **General Anesthesia –** maximum one hour • **Specialist Consultation –** one per calendar year, includes allowance for examination • **Localized Deliv. Of Chemo agent.** three teeth per quad in a three year period.
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	• 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. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : Administrative Services Only, Inc, Dept 66. 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 ASO, Inc. at:
(516) 396-5500 or (718) 204-7172

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IMPLANT AND IMPLANT RELATED SERVICES: **EFFECTIVE 1/17**

	Maximum Charge	Plan Pays
Endosteal Implant	$1,200.00	$1,200.00
Subperiosteal Implant	$1,200.00	$1,200.00
Transosseous Implant	$1,200.00	$1,200.00
Interim Abutment	$300.00	$300.00
Prefabricated Abutment	$475.00	$475.00
Custom Abutment	$475.00	$475.00
Abutment Supported Porcelain Ceramic Crown	$700.00	$700.00
Abutment Supported Porcelain/Metal Crown	$700.00	$700.00
Abutment Supported Crown	$600.00	$600.00
Abutment Supported Cast High Noble Metal Crown	$700.00	$700.00
Abutment Supported Noble Metal Crown	$600.00	$600.00
Implant Supported Porcelain Ceramic Crown	$1,000.00	$1,000.00
Implant Supported Porcelain/High Noble Metal Crown	$1,000.00	$1,000.00
Implant Supported High Noble Metal Crown	$1,000.00	$1,000.00

Radiographs of the entire arch are required for evaluation. There is a five-year frequency limitation for the replacement of prosthetic devices. Implants are limited to a maximum of 8 per lifetime.

Assistant Deputy Wardens / Deputy Wardens Association
Schedule of Allowances

DIAGNOSTIC	MAXIMUM CHARGE
ORAL EXAM	27.00
X-RAYS - FULL MOUTH SERIES	75.00
PERIAPICAL OR BITEWING X-RAY	6.00
PANORAMIC FILM	60.00
OCCLUSAL FILM	15.00
DIAGNOSTIC CASTS	30.00
SPACE MAINTAINER	150.00
CONE BEAM CT	200.00
PREVENTIVE	
PROPHYLAXIS-ADULT	60.00
PROPHYLAXIS-CHILD to age 19	45.00
FLUORIDE EXCL. PROPHY	15.00
SEALANT-PER TOOTH to age 19	25.00
RESTORATIVE	
SILVER AMALGAM 1 SURFACE	55.00
SILVER AMALGAM 2 SURFACE	65.00
SILVER AMALGAM 3 SURFACE	75.00
SILVER AMALGAM FOUR OR MORE SURFACE	80.00
COMPOSITE RESIN ANTERIOR 1	60.00
COMPOSITE RESIN ANTERIOR 2	70.00
COMPOSITE RESIN ANTERIOR 3	80.00
FOUR OR MORE SURFACES INCLUDING THE INCISAL ANGLE	90.00
PORCELAIN\METALLIC INLAY	
one surfaces	250.00
two surfaces	300.00
three surface	350.00
PIN RETENTION-PER TOOTH	25.00
CROWN-PORCELAIN WITH METAL	550.00
CROWN-PLASTIC WITH METAL	475.00
FULL OR 3/4 CAST CROWN	475.00
PORCELAIN LAMINATE	300.00
PORCELAIN JACKET	475.00
PREFAB SS CROWN-PRIMARY	85.00
PREFAB POST AND CORE	80.00
CAST POST AND CORE	130.00
CROWN BUILD UP	75.00
POST REMOVAL	100.00
ENDODONTICS	
PULP CAP	10.00
VITAL PULPOTOMY	75.00
APICOECTOMY-per tooth	275.00
APICOECTOMY,maximum per tooth	550.00
RETROGRADE FILLING	90.00
ROOT CANAL THERAPY	
anterior	400.00
bicuspid	450.00
molar	650.00
For Services provided by a board certified Endodontist	
ROOT CANAL THERAPY	
anterior	450.00
bicuspid	500.00
molar	700.00
RETREAT RCT-ANTERIOR	500.00
RETREAT RCT-BICUSPID	650.00
RETREAT RCT-MOLAR	800.00
ORAL SURGERY	
SIMPLE EXTRACTION	75.00
SURGICAL EXTRACTION	100.00
RETAINED ROOT	100.00
IMPACTION-SOFT TISSUE	125.00
IMPACTION-PARTIAL BONY	215.00
IMPACTION-COMPLETE BONY	250.00
ALVEOPLASTY-PER QUAD	125.00
BIOPSY OF ORAL TISSUE	85.00
CYST REMOVAL < 1.25CM	85.00
INCISION & DRAINAGE	55.00
ROOT RESECTION	150.00
MOBILIZATION TO AID ERUPTION	300.00
ADJUNCTIVE SERVICES	
SPECIALIST CONSULTATION	75.00
PALLIATIVE TREATMENT	35.00
BRUXISM APPLIANCE	120.00
GENERAL ANESTHESIA	75.00

PERIODONTICS	MAXIMUM CHARGE
PEDICLE SOFT TISSUE GRAFT	200.00
FREE SOFT TISSUE GRAFT	250.00
OSSEOUS GRAFT single site	125.00
OSSEOUS GRAFT per quadrant	375.00
LOCALIZED DELIV. OF CHEMO.AGENT --	50.00
GUIDED TISSUE	125.00
ROOT SCALING, GINGIVAL CURETTAGE and BITE	
CORRECTION,including prophylaxis,	
per treatment	50.00
per maintenance	55.00
Maximum payment-$200 in a calendar year	
PERIODONTAL SURGERY	
confirmation by charting and/or x-rays required per	
quadrant of at least 5 teeth	
GINGIVECTOMY, GINGIVOPLASTY and	
MUCOGINGIVAL SURGERY per quad	110.00
OSSEOUS SURGERY per quad	375.00
For Services provided by a board certified Periodontist	
ROOT SCALING, GINGIVAL CURETTAGE and BITE	
CORRECTION,including prophylaxis,	
per treatment	75.00
per maintenance	100.00
Maximum payment-$300 in a calendar year	
PERIODONTAL SURGERY	
confirmation by charting and/or x-rays required per	
quadrant of at least 5 teeth	
GINGIVECTOMY, GINGIVOPLASTY and	
MUCOGINGIVAL SURGERY per quad	150.00
OSSEOUS SURGERY per quad	500.00
PROSTHODONTICS	
DENTURE-PERMANENT OR IMMEDIATE	650.00
PARTIAL DENTURE-unilateral	280.00
PARTIAL DENTURE-bilateral	
acrylic base with clasps and rests	475.00
cast metal base	650.00
BRIDGE ABUTMENT	
porcelain with metal	550.00
plastic with metal	475.00
full cast	475.00
PONTICS	
porcelain with metal	550.00
plastic with metal	475.00
full cast	475.00
MARYLAND BRIDGE RETAINER	280.00
PRECISION ATTACHMENT	135.00
REPAIR COMP DENT BASE	100.00
REPLC MISS/BRKN TTH-COM DENT	90.00
REPAIR PART ACRYLIC SADDLE/BASE	100.00
REPAIR CAST FRAMEWORK	100.00
REPAIR OR REPLACE BROKEN CLASP	90.00
ADD TOOTH TO DENTURE	90.00
REPLACE BROKEN FACING	100.00
RELINE COMPLETE DENTURE-CHAIR	85.00
RELINE PARTIAL DENTURE-CHAIR	60.00
RELINE COMPLETE DENTURE-LAB	135.00
RELINE PARTIAL DENTURE-LAB	110.00
RECEMENT CROWN	35.00
RECEMENT BRIDGE	75.00
ORTHODONTICS	
Maximum $3,600 per covered individual	
INITIAL APPLICANCE-INCL DIAGNOSIS	600.00
REMOVABLE APPLIANCE-tooth guidance	270.00
POST-TREATMENT STABILIZATION APPLIANCE	150.00
ACTIVE TREATMENT-PER MONTH	100.00
Maximum: 24 months	2400.00
PASSIVE TREATMENT-PER 3 MONTHS	100.00
Maximum : 9 months	300.00

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