# I.A.T.S.E. NATIONAL HEALTH AND WELFARE FUND
# 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**

- To confirm eligibility, please call Self-Insured Dental Services at (516) 396-5500. **Eligible dependents** include spouses, unmarried children who have not yet attained their 19th birthday or 25th birthday if attending an accredited school or college on a full-time basis.

**ANNUAL MAXIMUM**

- $2,000 per covered individual in a calendar year

**ORTHODONTICS**

- Orthodontists will be reimbursed by the plan members in accordance with the discounted schedule listed below

| | MINOR TOOTH MOVEMENT | COMPREHENSIVE TREATMENT |
|---|---|---|
| REMOVABLE APPLIANCE | $270.00 | $270.00 |
| FIXED APPLIANCE | $300.00 | $480.00 |
| ACTIVE TREATMENT, PER MONTH (Max 24 months) | $60.00 | $ 60.00 |
| PASSIVE TREATMENT, PER 3 MTHS (Max 9 months) | | $ 60.00 |
| POST TREATMENT STABILIZATION DEVICE | | $120.00 |
| MAXIMUM CHARGE | $780.00 | $2,520.00 |

**DEDUCTIBLE**

- None

**PLAN LIMITATIONS**

- **Examination** – two per calendar year
- **Prophylaxis** – two per calendar year
- **X-rays** - $75 maximum per calendar year
- **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 19, lifetime maximum one application per tooth.
- **Fluoride treatment** – to age 19, maximum two applications per year
- **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – per visit, maximum $240 per calendar year
- **Periodontal surgery –** charting and x-rays required; 1 in 36 consecutive months
- **Specialist consultation –** two per 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:** 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. Claims must be filed within 18 months of the date of service.**
- 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. 113
  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 11/02

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

**I.A.T.S.E. NATIONAL HEALTH &WELFARE FUND**

**SCHEDULE OF MAXIMUM CHARGES & MEMBER CO-PAYMENTS**

| | | |
|---|---|---|
| **DIAGNOSTIC** | | |
| ORAL EXAM | 28.00 | |
| X-RAYS (FULL MOUTH SERIES) | 70.00 | |
| PA OR BW EACH FILM | 8.00 | |
| EACH ADDITIONAL FILM | 5.00 | |
| OCCLUSAL FILM | 15.00 | |
| POSTERIOR-ANTERIOR, LATERAL FILM | 30.00 | |
| TMJ FILM | 45.00 | |
| EXTRAORAL FILM | 25.00 | |
| PANORAMIC OR CEPHALPMETRIC FILM | 55.00 | |
| PALLIATIVE-EMERGENCY TRT | 40.00 | |
| CONSULTATION BY A SPECIALIST | 50.00 | |
| **PREVENTIVE** | | |
| PROPHYLAXIS-ADULT | 50.00 | |
| PROPHYLAXIS-CHILD | 35.00 | |
| SEALANT | 25.00 | |
| FLUORIDE EXCL. PROPHY | 17.00 | |
| SPACE MAINTAINER | 150.00 | |
| **BASIC RESTORATIVE** | | |
| AMALGAM - 1 SURFACE-Primary | 50.00 | |
| AMALGAM - 2 SURFACE-Primary | 65.00 | |
| AMALGAM - 3 SURFACE-Primary | 75.00 | |
| AMALGAM - 4 SURFACE-Primary | 85.00 | |
| AMALGAM - 1 SURFACE-Permanent | 60.00 | |
| AMALGAM - 2 SURFACE-Permanent | 75.00 | |
| AMALGAM - 3 SURFACE-Permanent | 85.00 | |
| AMALGAM - 4 SURFACE-Permanent | 95.00 | |
| RESIN-1 SURFACE-ANTERIOR | 70.00 | |
| RESIN-2 SURFACE-ANTERIOR | 90.00 | |
| RESIN-3 SURFACE-ANTERIOR | 110.00 | |
| INCISAL ANGLE | 110.00 | |
| RESIN-1 SURFACE-POSTERIOR | 75.00 | |
| RESIN-2 SURFACE-POSTERIOR | 100.00 | |
| RESIN-3 OR MORE SURFACES-POSTERIOR | 115.00 | |
| *MAXIMUM COMPOSITE PER TOOTH* | 150.00 | |
| **MAJOR RESTORATIVE** | | |
| METALLIC OR PORCELAIN INLAY-1 SRF | 275.00 | * |
| METALLIC OR PORCELAIN INLAY-2 SRF | 325.00 | * |
| METALLIC OR PORCELAIN INLAY-3 SRF | 350.00 | * |
| CROWN-PLASTIC | 350.00 | *** |
| CROWN-PLASTIC TO METAL | 450.00 | *** |
| CROWN-PORCELAIN | 475.00 | *** |
| CROWN-PORCELAIN TO METAL | 500.00 | *** |
| CROWN-FULL CAST | 475.00 | *** |
| CROWN 3/4 CAST | 450.00 | *** |
| RECEMENT INLAY | 40.00 | |
| RECEMENT CROWN | 50.00 | |
| PREFAB SS CROWN-PRIMARY | 125.00 | |
| PIN RETENTION-PER TOOTH | 25.00 | |
| CAST POST AND CORE | 130.00 | |
| PREFAB POST AND CORE | 85.00 | |
| PORCELAIN LAMINATE | 425.00 | *** |
| **ENDODONTICS** | | |
| PULP CAP | 30.00 | |
| VITAL PULPOTOMY | 85.00 | |
| ROOT CANAL THERAPY-1 CANAL | 350.00 | |
| ROOT CANAL THERAPY-2 CANALS | 425.00 | |
| ROOT CANAL THERAPY-3 CANALS | 475.00 | |
| ROOT CANAL THERAPY-4+ CANALS | 525.00 | |
| APICOECTOMY-1ST ROOT | 275.00 | |
| APICOECTOMY-MAXIMUM PER TOOTH | 400.00 | |
| RETROGRADE FILLING | 100.00 | |
| ROOT RESECTION | 150.00 | |

| | | |
|---|---|---|
| **PROSTHODONTICS** | | |
| COMPLETE UPPER OR LOWER DENTURE | 650.00 | ** |
| IMMEDIATE FULL UPPER OR LOWER DENTURE | 650.00 | ** |
| UNILATERAL PARTIAL DENTURE | 300.00 | |
| PARTIAL DENTURE-CAST METAL BASE | 750.00 | ** |
| PARTIAL DENTURE-ACRYLIC BASE | 400.00 | ** |
| DENTURE ADJUSTMENT | 50.00 | |
| REPAIR COMP DENT BASE | 90.00 | |
| REPLC MISS/BRKN TTH-COM DENT | 75.00 | |
| REPAIR PART ACRYLIC SADDLE/BASE | 90.00 | |
| REPAIR CAST FRAMEWORK | 125.00 | |
| REPAIR OR REPLACE BROKEN CLASP | 110.00 | |
| REPLACE BROKEN TEETH- PER TOOTH | 75.00 | |
| ADD CLASP TO EXISTING PART DENT | 110.00 | |
| REBASE DENTURE | 250.00 | |
| RELINE COMPLETE DENTURE-CHAIR | 130.00 | |
| RELINE PARTIAL DENTURE-CHAIR | 125.00 | |
| RELINE COMPLETE DENTURE-LAB | 200.00 | |
| RELINE PARTIAL DENTURE-LAB | 175.00 | |
| TISSUE CONDITIONING | 65.00 | |
| PONTIC-CAST METAL | 450.00 | *** |
| PONTIC-PORCELAIN TO METAL | 475.00 | *** |
| PONTIC-RESIN WITH METAL | 450.00 | *** |
| ABUTMENT CROWN-PORCELAIN WITH METAL | 500.00 | *** |
| ABUTMENT CROWN-FULL CAST | 475.00 | *** |
| CAST METL RETNR-ACID ETCH BRIDGE | 300.00 | |
| RECEMENT BRIDGE | 75.00 | |
| REPLACE FACING | 90.00 | |
| PRECISION ATTACHMENT | 85.00 | |
| **PERIODONTICS** | | |
| GINGIVECTOMY-PER QUAD | 250.00 | |
| OSSEOUS SURGERY-PER QUAD | 475.00 | *** |
| OSSEOUS GRAFT-SINGLE SITE | 100.00 | |
| OSSEOUS GRAFT-PER QUAD | 250.00 | |
| OSSEOUS GRAFT-MAXIMUM PER JAW | 350.00 | |
| PEDICLE SOFT TISSUE GRAFT | 200.00 | |
| FREE SOFT TISSUE GRAFT | 300.00 | |
| OCCLUSAL ADJUSTMENT COMPLETE | 70.00 | |
| CURETTAGE, SCALE\ROOT PLANING- PER QUAD | 70.00 | |
| CURETTAGE, SCALE\ROOT PLANING- MAX PER VISIT | 110.00 | |
| PERIODONTAL MAINTENANCE PROCEDURE | 70.00 | |
| **ORAL SURGERY** | | |
| SIMPLE EXTRACTION | 75.00 | |
| EXTRACTION ROOT REMOVAL | 125.00 | |
| SURGICAL EXTRACTION | 145.00 | |
| IMPACTION-SOFT TISSUE | 200.00 | |
| IMPACTION-PARTIAL BONY | 225.00 | |
| IMPACTION-COMPLETE BONY | 300.00 | |
| EXTRACTION OF RESIDUAL ROOT | 150.00 | |
| BIOPSY OF SOFT TISSUE | 100.00 | |
| BIOPSY OF HARD TISSUE | 115.00 | |
| ALVEOPLASTY-PER QUAD | 125.00 | |
| REMOVAL OF CYST OR TUMOR < 1.25CM. | 125.00 | |
| REMOVAL OF CYST OR TUMOR > 1.25CM. | 150.00 | |
| INCISION & DRAINAGE INTRAORAL | 100.00 | |
| FRENULECTOMY | 150.00 | |
| ROOT AMPUTATION | 150.00 | |
| HEMISECTION | 175.00 | |
| GENERAL ANESTHESIA/IV SEDATION-1ST 30 MIN | 150.00 | |

*** Includes a $50 Co-Payment**

**** Includes a $75 Co-Payment**

***** Includes a $100 Co-Payment**

Eff 5/99