LOCAL 807 LABOR MANAGEMENT HEALTH FUND
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	• Includes 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
ANNUAL MAXIMUM	• The annual maximum is $2,500 per person
DEDUCTIBLE	• There is no deductible
WAITING PERIOD	• There is a 6 month waiting period from the date of eligibility for crowns/ prosthetic devices and orthodontics
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays – panoramic or full mouth series** – one in 24 consecutive months • **Sealant** –posterior teeth, to age 19, lifetime maximum one application per lifetime. • **Fluoride treatment** – to age 19, maximum two applications per year • **Palliative treatment** – no other treatment that same visit • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum two quadrants per visit, 4 treatments per year • **Specialist consultation** – one per year, per specialty, includes allowance for examination • **Replacement of crowns, bridges and dentures** – not more than once in 5 years • **General Anesthesia/IV Sedation** – First 30 minutes only • **Orthodontics** – 25 active months and 9 passive months for each individual to age 19 • **Incision & drainage** – no other treatment that visit
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-payments • **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 charge.
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. 75 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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Self-Insured Dental Services / Administrative Services Only, Inc. Dental Plan Administrators

Local 807 Labor Management Health Fund
Dental Schedule of Allowances

DIAGNOSTIC	PLAN PAYS	MEMBER CO-PAY
ORAL EXAM	17.00	
FULL MOUTH SERIES	40.00	
PANORAMIC FILM	45.00	
INTRAORAL X-RAY , first film	5.00	
INTRAORAL X-RAY, each additional film	5.00	
BITEWING, per film	5.00	
OCCLUSAL FILM	15.00	
EXTRAORAL, TMJ FILM	25.00	
POSTERIOR-ANTER., LATERAL	25.00	
CEPHALOMETRIC FILM	40.00	
PREVENTIVE		
PROPHYLAXIS-ADULT	30.00	
PROPHYLAXIS-CHILD	25.00	
FLUORIDE EXCL. PROPHY	20.00	
SEALANT-PER TOOTH	20.00	
SPACE MAINTAINER	150.00	
RESTORATIVE		
AMALGAM FILLINGS PRIMARY OR PERMANENT		
one surface	35.00	10.00
two surfaces	45.00	10.00
three surfaces	50.00	10.00
four surfaces	55.00	10.00
SEDATIVE FILLING	20.00	
COMPOSITE RESIN-ANTERIOR OR POSTERIOR		
one surface	40.00	10.00
two surface	50.00	10.00
three or more surfaces	60.00	10.00
incisal angle	70.00	10.00
METALLIC INLAY		
one surface	200.00	
two surfaces	230.00	
three surfaces	260.00	
METALLIC ONLAY	70.00	
PORCELAIN INLAY		
one surface	200.00	
two surfaces	230.00	
three surfaces	260.00	
CROWN/ABUTMENT-PLASTIC WITH METAL	325.00	50.00
CROWN/ABUTMENT-PORCELAIN JACKET	300.00	50.00
CROWN/ABUTMENT-PORCELAIN WITH METAL	375.00	50.00
FULL OR 3/4 CAST CROWN/ABUTMENT	300.00	50.00
ACRYLIC JACKET	250.00	
LABIAL VENEER-lab processed	275.00	
STAINLESS STEEL CROWN-PRIMARY	100.00	
PREFAB POST AND CORE	75.00	
CAST POST & CORE	125.00	
PIN RETENTION-PER TOOTH	25.00	
RECEMENT CROWN OR INLAY	30.00	
ENDODONTICS		
PULP CAP	10.00	
VITAL PULPOTOMY	60.00	
ROOT CANAL THERAPY-1 CANAL	175.00	50.00
ROOT CANAL THERAPY-2 CANALS	225.00	50.00
ROOT CANAL THERAPY-3 CANALS	300.00	50.00
APICOECTOMY	175.00	50.00
APICO-MAXIMUM PER TOOTH	400.00	50.00
RETROGRADE FILLING-per root	85.00	
ADJUNCTIVE SERVICES		
PALLIATIVE TREATMENT	30.00	
GENERAL ANESTHESIA-1ST 30 MIN	125.00	
IV SEDATION- 1S 30 MIN	90.00	
CONSULTATION BY SPECIALIST	50.00	

PERIODONTICS	PLAN PAYS	MEMBER CO-PAY
PERIO SCALE-PER QUAD	50.00	
maximum 2 quadrants per visit		
OCCLUSAL ADJUSTMENT	75.00	
PERIO MAINTENANCE		
following periodontal surgery	75.00	
BRUXISM APPLIANCE	200.00	
GINGIVECTOMY,GINGIVAL FLAP OR MUCO-		
GINGIVAL SURGERY PER QUAD	200.00	50.00
FREE SOFT GRAFT-PER QUAD	250.00	
OSSEOUS GRAFT-PER SITE	125.00	
OSSEOUS GRAFT, MAX PER QUAD	250.00	
OSSEOUS SURGERY including gingivectomy		
per quadrant	300.00	50.00
PEDICLE SOFT TISSUE GRAFT	200.00	
PROSTHODONTICS		
DENTURE-PERMANENT OR IMMEDIATE	550.00	50.00
PARTIAL DENTURE-ACRYLIC BASE	375.00	50.00
PARTIAL DENTURE-CAST BASE	425.00	50.00
UNILATERAL PARTIAL DENTURE	150.00	50.00
ADJUST DENTURE COM. OR PARTIAL	35.00	
REPAIR PART ACRYLIC SADDLE/BASE	75.00	
REPAIR CAST FRAMEWORK	100.00	
BROKEN DENTURE BASE	90.00	
REPLACE BROKEN TOOTH	85.00	
REPLACE BROKEN FACING	100.00	
REPLACE BROKEN CLASP	85.00	
ADD TOOTH TO EXISTING PARTIAL DENT	85.00	
ADD CLASP TO EXISTING PART DENT	85.00	
RELINE COMPLETE DENTURE-CHAIR	75.00	
RELINE PARTIAL DENTURE-CHAIR	60.00	
RELINE COMPLETE DENTURE-LAB	125.00	
RELINE PARTIAL DENTURE-LAB	100.00	
PONTIC-FULL CAST	300.00	50.00
PONTIC-PORCELAIN TO METAL	375.00	50.00
PONTIC-RESIN WITH METAL	300.00	50.00
CAST METAL RETR-ACID ETCH BRIDGE	230.00	
TISSUE CONDITIONING	40.00	
RECEMENT BRIDGE	50.00	
RECEMENT SPACE MAINTAINER	40.00	
ORAL SURGERY		
SIMPLE EXTRACTION	55.00	
SURGICAL EXTRACTION	115.00	
RETAINED ROOT	90.00	
IMPACTION-SOFT TISSUE	115.00	
IMPACTION-PARTIAL BONY	185.00	
IMPACTION-COMPLETE BONY	225.00	
BIOPSY OF ORAL TISSUE	135.00	
ORAL ANTRAL FISTULA CLOSURE	200.00	
ALVEOPLASTY PER QUAD	125.00	
CYST REMOVAL < 1.25CM	150.00	
CYST REMOVAL > 1.25CM.	190.00	
INCISION & DRAINAGE	50.00	
FRENULECTOMY	150.00	
ROOT RESECTION	150.00	
HEMISECTION	150.00	
ORTHODONTICS		
DIAGNOSIS & INITIAL APPLIANCES		
removable appliance OR	225.00	
fixed appliance OR	600.00	
HARMFUL HABIT APPLIANCE	225.00	
ACTIVE TREATMENT, per mth of treatment	75.00	
maximum- 25 months		
PASSIVE TREATMENT, per 3 mths	75.00	
maximum- 9 mths		
POST-TREATMENT STABILIZATION DEVICE	100.00	

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