



Office & Professional Employees • Locals 30 & 537 Trust Funds

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O.P.E.I.U. LOCALS 30 & 537 BASIC DENTAL PLAN "A" *TABLE OF ALLOWANCES

Effective July 1, 2005

ADA CODES	DESCRIPTION	MAXIMUM FEE ALLOWANCE	% BENEFIT PAYMENT	ADA CODES	DESCRIPTION	MAXIMUM FEE ALLOWANCE	% BENEFIT PAYMENT
DIAGNOSTIC — (0110-0340)				PROSTHETICS — (5110-6960)			
0110	Exam (once every 6 months, 180 days)	42.00	100%	PROSTHODONTICS—Removable Complete Dentures—including adjustments within 6 months.			
0120	Periodic Exam	33.00	100%	5110	Complete upper	725.00	90%
0130	Emergency Exam	54.00	100%	5120	Complete lower	725.00	90%
0210	Full Mouth X-Ray w/ bitewings (once every two years)	71.00	100%	PARTIAL DENTURES—(Including adjustments, clasps and teeth)			
0220	Single film	19.00	100%	5230	Partial Lower	725.00	90%
0230	Additional films up to 10	10.00	100%	5250	Partial Upper	725.00	90%
0240	Occlusion View	24.00	100%	ADJUSTMENTS TO DENTURES—(After 6 months)			
0250	Max. / Extra Oral, One Film	42.00	100%	5410	Adjustment to denture	54.00	90%
0272	Bitewing — Two Films	36.00	100%	REPAIRS TO DENTURES			
0274	Bitewing — Four Films	42.00	100%	5520	Replace broken teeth—each tooth	60.00	90%
0330	Panoramic Survey	60.00	100%	5610	Broken Denture—No teeth involved	76.00	90%
0340	Cephalometric Film	60.00	100%	5640	Replace each additional	60.00	90%
PREVENTIVE — (1110-1520)				5650	Adding tooth to denture to replace natural extraction	92.00	90%
1110	Prophy 14 & Older (once every 6 months, 180 days)	70.00	100%	5660	Adding tooth to partial denture to replace extracted tooth with clasp	113.00	90%
1120	Prophy to age 14 (once every 6 months, 180 days)	54.00	100%	5690	Each additional tooth with clasp	49.00	90%
1210	Prophy / Fluoride Treatment	70.00	100%	OTHER PROSTHETIC SERVICES			
1351	Sealant per tooth (to age 14)	19.00	100%	5710	Denture Duplication	242.00	90%
1510	Space Maintainer	178.00	100%	5750	Denture Reline	210.00	90%
RESTORATIVE — (2110-2952) Allowance includes all necessary bases, pulp caps, buildups, etc.				5850	Tissue Conditioning, per denture	76.00	90%
2110	Amalgam — One Surface — Primary	54.00	90%	FIXED BRIDGES BRIDGE PONTICS			
2120	Amalgam — Two Surface — Primary	70.00	90%	6210	Cast Gold Pontic	446.00	90%
2130	Amalgam — Three or more — Primary	76.00	90%	6240	Porcelain Fused to Semi-Precious Metal	537.00	90%
2140	Amalgam — One Surface — Permanent	70.00	90%	6241	Porcelain Fused to Non-Precious Metal	510.00	90%
2150	Amalgam — Two Surface — Permanent	76.00	90%	6250	Plastic Resin with High Noble	537.00	90%
2160	Amalgam — Three or More — Permanent	92.00	90%	6750	Abutment Crown Porcelain to Metal	591.00	90%
2310	Acrylic, Plastic, Composite (Per Restoration)	92.00	90%	6920	Dowel Pin Gold	97.00	90%
2330	Composite Resin One Surface	92.00	90%	6930	Bridge Recement	60.00	90%
2331	Composite Resin Two Surfaces	102.00	90%	6960	Dowel Pin Metal-Cast	97.00	90%
2332	Composite Resin Three Surfaces	135.00	90%	ORAL SURGERY — (7110-7983)			
2335	Composite Resin Incisal Angle	140.00	90%	7110	Uncomplicated single extraction	76.00	90%
2510	One Surface Inlay	296.00	90%	7120	Each additional tooth (local anesthesia only)	60.00	90%
2520	Two Surface Inlay	387.00	90%	7210	Surgical removal of erupted tooth	97.00	90%
2530	Three or More Surface Inlay	414.00	90%	7220	Extract tooth Soft Tissue impact	178.00	90%
2540	Onlay In Addition per tooth	92.00	90%	7230	Extract tooth partial bony impact	210.00	90%
2710	Crown — Resin-Plastic/Acrylic	296.00	90%	7240	Extract tooth complete bony impact	269.00	90%
2720	Crown — Resin-with high noble metal	414.00	90%	7250	Residual root recovery surgery	269.00	90%
2740	Crown — Porcelain / Ceramic	473.00	90%	7260	Closure of oral fistula/root recovery	161.00	90%
2750	Crown — Porcelain fused to semi-precious metal	591.00	90%	7310	Alveolectomy in addition to removal	140.00	90%
2751	Crown — Porcelain fused to non-precious metal	537.00	90%	7320	Alveolectomy per quad	108.00	90%
2790	Crown — Gold full cast	532.00	90%	7350	Alveolectomy with ridge extension	161.00	90%
2810	Crown — 3/4 Gold	473.00	90%	7450	Removal of cast or tumor to 1/2	194.00	90%
2830	Stainless Steel Primary	97.00	90%	7451	Removal of cast or tumor over 1/2	360.00	90%
2892	Crown — Post & Core in addition	129.00	90%	7470	Removal of Palatal Torus	129.00	90%
2910	Recement Inlays	42.00	90%	7471	Removal of man tori per quad	151.00	90%
2920	Recement Crown	54.00	90%	7510	Incision/drainage of abscess	76.00	90%
2952	Crown Pin	113.00	90%	7530	Removal of foreign body (soft tissue)	60.00	90%
ENDODONTICS — (3210-3420)				7540	Removal of foreign body from bone	92.00	90%
3220	Therapeutic/Vital Pulpotomy	76.00	90%	7550	Bone abscess superficial	113.00	90%
3310	Single Root Canal	355.00	90%	7910	Suture of soft tissue injury	81.00	90%
3320	Bi-Root Canal	414.00	90%	7960	Frenectomy	177.00	90%
3330	Tri-Root Canal	532.00	90%	7970	Excision of hyperplastic tissue	177.00	90%
3340	Four Canals	532.00	90%	7980	Removal of salivary calculus	129.00	90%
3410	Apicoectomy / Separate Procedure	296.00	90%	7982	Dilation of salivary duct	76.00	90%
3420	Apicoectomy with Root Canal	355.00	90%	7983	Closure of salivary fistula	258.00	90%
PERIODONTICS — (4110-4910) Must submit perio charting.				MINOR TREATMENT TO CONTROL HARMFUL HABITS			
4210	Gingivectomy/Gingivoplasty—per quad	296.00	90%	8110	ORTHODONTIC LIFETIME (75% of initial banding, quarterly thereafter)	1350.00	MAXIMUM BENEFIT
4211	Gingivectomy/Gingivoplasty—single site	54.00	90%	8210	Appliances habit control removable	177.00	90%
4220	Gingival Curettage—per quad	60.00	90%	8220	Appliances habit control fixed	177.00	90%
4260	Osseous / Gingival Surgery—per quad	430.00	90%	ANESTHESIA			
4261	Osseous Graft—single site	76.00	90%	9220	General anesthesia/surgical procedure only	156.00	90%
4330	Correction of Occlusion — Complete	76.00	90%	UNCLASSIFIED TREATMENT			
4341	Root Planing per quad	86.00	90%	9110	Palliative Treatment of Dental pain, minor procedures	60.00	90%
4910	Periodontal Prophylaxis (once every 3 months, 90 days)	86.00	90%	9310	Special consultation by specialist	71.00	90%
				9630	Other drugs and/or medicaments	27.00	90%

Above benefits payable after satisfying an annual deductible of \$50.00 per person. Annual maximum benefit \$1350.00. Pre-authorization is required when services exceed \$500.00
See Reverse Side for Dental Limitations and Exclusions

* If your employer is contributing less than the prevailing rate to cover the costs of the benefits above, coverage will be prorated accordingly based on the amount of the contribution divided by the prevailing rate.

DENTAL LIMITATIONS AND EXCLUSIONS

This Plan does not pay expenses for:

1. Any course of treatment which will cost over \$500 which is not pre-authorized.
2. Any orthodontia which is not pre-authorized.
3. Any procedures which began before the date the covered person became eligible under this Plan, or began after the individual ceased eligibility. Any supplies furnished in connection with such procedure, except that X-rays and prophylaxis treatment will not be considered as the beginning of a dental procedure.
4. Separate charges for Analgesia and/or Nitrous Oxide (except for general anesthesia given by a dentist for covered oral surgery procedure).
5. More than one oral examination or prophylaxis during any period of six consecutive months (180 days).
6. Temporary full prosthesis. The term "prosthesis" means any crown or any fixed or removable denture.
7. Replacement of an existing prosthesis which, in the opinion of the attending doctor, is or can be made satisfactory.
8. Replacement of a prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth, or (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and is being replaced by a permanent prosthesis, or (c) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.
9. Replacement of a lost or stolen appliance.
10. Adjustments or relining of a prosthesis within six months after the prosthesis is initially furnished.
11. Any treatment by any method for temporomandibular joint dysfunction (TMJ).
12. Procedures which are necessary solely to increase vertical dimension, or restore the occlusion.
13. Implantology.
14. Dental procedures for cosmetic reasons, unless performed within two years after an accident to repair or alleviate damage from that accident which occurred while covered.
15. Hospital expenses incurred for any dental procedure performed (covered or not covered).
16. Dietary planning, oral hygiene instruction or training in preventive dental care.
17. Any services rendered by a member of the immediate family of the person or of the person's spouse.
18. Any charge above allowable charges or for a procedure determined not to be necessary dental treatment as determined by the Board of Trustees.
19. Charges for completion of claim forms.
20. Charges for missed or broken appointments.
21. Claims not submitted within 12 months after expenses were incurred, except in absence of legal capacity. Additional information requested by the Claims Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.
22. Charges for expenses incurred outside the United States unless when traveling and in need of urgent or emergency care.