IUOE LOCAL 37 DENTAL PLAN

CHANGES EFFECTIVE 1/1/2024

YEARLY DENTAL MAXIMUM: $2,000.00 PER PERSON CHILDREN UNDER THE AGE OF 19 NOT SUBJECT TO THE DENTAL MAXIMUM

YEARLY DENTAL DEDUCTIBLE: $100.00 WITH A FAMILY CAP OF $300.00

PREVENTIVE CARE - 80%

0120	
0145	
0150	
0210	0701
0220	0702
0230	0703
0240	0705
0250	0706
0251	0707
0270	0708
0272	0709
0273	
0274	
0277	
0330	
0340	
0350	
1110	
1120	
1206	
1208	
1510	
1516	
1517	
1520	
1526	
1527	
1551	
1552	
1553	
1556	
1557	
1558	
1575	

BASIC - 80%

0140	0387	0802	3221	3430	4920	5422	5760	6073	6950	9610
0160	0388	0803	3222	3431	4921	5511	5761	6074	6980	9612
0170	0389	0804	3230	3432	5110	5512	5765	6075	6985	9613
0171	0391	1351	3240	3450	5120	5520	5810	6076	7111	9630
0180	0393	1352	3310	3460	5130	5611	5811	6077	7140	9910
0190	0394	1353	3320	3470	5140	5612	5820	6081	9110	9911
0191	0395	1354	3330	3471	5211	5621	5821	6090	9120	9920
0310	0396	1355	3331	3472	5212	5622	5850	6091	9210	9930
0322	0414	2140	3332	3473	5213	5630	5851	6093	9211	9932
0364	0415	2150	3333	3501	5214	5640	5862	6095	9212	9933
0365	0416	2160	3346	3502	5221	5650	5863	6110	9215	9934
0366	0417	2161	3347	3503	5222	5660	5864	6111	9219	9935
0367	0418	2330	3348	3910	5223	5670	5865	6112	9222	9941
0369	0419	2331	3351	3911	5224	5671	5866	6113	9223	9942
0370	0422	2332	3352	3920	5225	5710	5867	6114	9230	9943
0371	0423	2335	3353	3921	5226	5711	5875	6115	9239	9944
0372	0425	2390	3355	3950	5227	5720	5876	6116	9243	9945
0373	0431	2391	3356	4322	5228	5721	6055	6117	9248	9946
0374	0460	2392	3357	4323	5282	5725	6056	6118	9310	9950
0380	0470	2393	3410	4341	5283	5730	6057	6119	9311	9951
0381	0600	2394	3421	4342	5284	5731	6068	6192	9410	9952
0382	0601	2940	3425	4346	5286	5740	6069	6194	9420	9995
0383	0602	3110	3426	4355	5410	5741	6070	6920	9430	9996
0385	0603	3120	3428	4381	5411	5750	6071	6930	9440	
0386	0801	3220	3429	4910	5421	5751	6072	6940	9450	

PPE (Personal Protective Equipment) - Basic

MAJOR - 80%

2410	2652	2783	2941	2991	6067	6101	6205	6601	6634	6792
2420	2662	2790	2949	6010	6080	6102	6210	6602	6710	6793
2430	2663	2791	2950	6011	6082	6103	6211	6603	6720	6794
2510	2664	2792	2951	6012	6083	6104	6212	6604	6721	6795
2520	2710	2794	2952	6013	6084	6105	6214	6605	6722	7994
2530	2712	2799	2953	6040	6085	6106	6240	6606	6740	
2542	2720	2910	2954	6050	6086	6107	6241	6607	6750	
2543	2721	2915	2955	6051	6087	6197	6242	6608	6751	
2544	2722	2920	2957	6058	6088	6122	6243	6609	6752	
2610	2740	2921	2971	6059	6089	6123	6245	6610	6753	
2620	2750	2928	2975	6060	6092	6190	6250	6611	6780	
2630	2751	2929	2976	6061	6094	6191	6251	6600	6781	
2642	2752	2930	2980	6062	6096	6120	6252	6612	6782	
2643	2753	2931	2981	6063	6097	6121	6253	6613	6783	
2644	2780	2932	2982	6064	6098	6195	6545	6614	6784	
2650	2781	2933	2989	6065	6099	6198	6548	6615	6790	
2651	2782	2934	2990	6066	6100	6199	6549	6624	6791	

*********PPO Network - Cigna Dental PPO Shared Administration Plus - Group # 3341999*********

Out of Network available, payment is based on our Fee Schedule, and payment will be issued to the provider with "Signature on file". Payment will not be issued to the patient without proof of payment

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CHANGES EFFECTIVE 1/1/2024

MOST ASKED QUESTIONS

Age limit on fluoride - **No**

Billed on prep date or seat - **Seat**

Cleaning must be 6 months apart -**No**

Coordination of benefits - **Standard**

Downgrade on composite to amalgam - **No**

Downgrade or upgrade - **No**

Frequency limit on dental services - **No**

Missing tooth clause - **No**

Out of Network Provider available - **Yes**

Pre-auth required - **No**

Replacement clause - **5 years dentures/Partial only**

Sealants - **No tooth # exclusion or age limit**

Waiting Period - **No**

X-rays - **No frequency limit**

X-rays required - **No**

* D0470 requires reason to determine coverage
* D9944, D9945, D9946 covered for bruxism only under dental any other reason contact fund office
* All Unspecified ADA need description to determine coverage

Maximum age for dependent child is 26

PPE (Personal Protective Equipment) covered under basic

ORAL SURGERY

80%

Major Medical - Contact Fund Office for the Medical deductible amount

0472	0485	4261	4278	7251	7290	7320
0473	0486	4263	4283	7260	7291	7321
0474	0502	4264	4285	7261	7292	7340
0475	4210	4265	4286	7270	7293	7350
0476	4211	4266	5982	7272	7294	7510
0477	4212	4267	5987	7280	7295	7511
0478	4230	4268	5988	7282	7296	7520
0479	4231	4270	7210	7283	7297	7521
0480	4240	4273	7220	7284	7298	7922
0481	4241	4274	7230	7285	7299	7953
0482	4245	4275	7240	7286	7300	7957
0483	4249	4276	7241	7287	7310	7961
0484	4260	4277	7250	7288	7311	

ORTHODONTIC

LTM $1,000 - 80%

8010	8070	8220	8681	8697	8702
8020	8080	8660	8690	8698	8703
8030	8090	8670	8695	8699	8704
8040	8210	8680	8696	8701	

Dental & Oral Surgery Claims

CLAIMS MAILING ADDRESS

OE 37 c/o DECISION SCIENCE INC
3615 NORTH POINT BLVD SUITE C
BALTIMORE, MD 21222

Provider Line

1-855-969-3419 / 410-650-4740

Fax Line

443-797-8918 (Effective 4/1/2023)

Claims can be faxed no x-rays or charting notes wanted

No EDI available

NON COVERED

0411	1330	1709	2960	9947	9970	9990
0412	1701	1710	2961	9948	9971	9991
0604	1702	1711	2962	9949	9972	9992
0605	1703	1712	2983	9953	9973	9993
0606	1704	1713	5986	9954	9974	9994
1301	1705	1714	7939	9955	9975	9997
1310	1706	1781	9912	9956	9985	
1320	1707	1782	9938	9957	9986	
1321	1708	1783	9939	9961	9987	

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