32BJ NORTH HEALTH FUND
32BJ 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	• Eligibility is determined according to the definition and requirements outlined in the Building Service 32BJ Health Fund Summary Plan Description. **Eligible dependents** include the lawful spouse and unmarried qualified children until the end of the month in which the dependent child turns 26.
PLAN YEAR	• January 1st through December 31st
PLAN MAXIMUM	• $2,500 per calendar year per covered individual
ORTHODONTIC MAXIMUM	• $2,500 lifetime maximum per covered individual
DEDUCTIBLE	• None
PLAN LIMITATIONS	• **Examination** – one in six months • **Prophylaxis** – one in six months • **X-rays –** any combination – maximum $28 per calendar year • **X-rays – Full Mouth Series and Panorex** – once every thirty-six months • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored posterior teeth, once every 24 months, to age 16 • **Fluoride treatment** –maximum one application per six months, to age 16 • **Periodontal surgery –** charting and x-rays required; once per lifetime • **Periodontal Maintenance –** must be rendered by a periodontist, only payable if osseous surgery was covered by the fund. • **Orthodontics –** $2,500 maximum per covered individual, 30 months of consecutive treatment • **Specialist consultation –** no other treatment that same visit, includes allowance for exam • **Rebasing or relining denture** – once in a three year period
PRE-TREATMENT REVIEW	• All treatment plans over $1,500 must be pre-authorized. • Any services involving crowns, bridges, dentures, major oral surgery, periodontal surgical procedures and orthodontic treatment require prior approval. • Pre-op periapical x-rays required for crowns, veneers, 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 • **Please note-** a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible, and must be completed by the provider that submitted the treatment plan.
PERMISSIBLE CHARGES	• **Covered and reimbursable services, no co-payment:** None • **Covered and reimbursable services, with co-payment:** only established co-payment • **Covered but not reimbursable services:** Schedule allowance and established co-payment • **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 the plans allowance 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. • **Claims must be submitted within 180 days of date of service.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting Mail claims to : Administrative Services Only, Inc. P.O. Box 9011 Lynbrook, NY 11563 • Claims may also be submitted electronically using **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) 394-9485 or (877) 322-5385

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32BJ NORTH HEALTH FUND
SCHEDULE OF ALLOWANCES

PROCEDURE	MAXIMUM CHARGE	PLAN PAYS	MEMBER PAYS
I-DIAGNOSTIC			
ORAL EXAM	12.00	12.00	0.00
FULL MOUTH OR PANOREX	20.00	20.00	0.00
PERIAPICAL - PER FILM	2.00	2.00	0.00
BITEWING - PER FILM	2.00	2.00	0.00
OCCLUSAL FILM	5.00	5.00	0.00
II-PREVENTIVE			
PROPHYLAXIS- ADULT	30.00	30.00	0.00
PROPHYLAXIS- CHILD	30.00	30.00	0.00
FLUORIDE EXCL. PROPHY	20.00	20.00	0.00
SEALANT	6.00	6.00	0.00
SPACE MAINTAINER	65.00	65.00	0.00
SPACE MAINTAINER - BILATERAL	125.00	125.00	0.00
III-RESTORATIVE			
AMALGAM - 1 SURFACE	30.00	30.00	0.00
AMALGAM - 2 SURFACES	45.00	45.00	0.00
AMALGAM - 3 SURFACES	55.00	55.00	0.00
AMALGAM - 4 OR MORE SURFACES	55.00	55.00	0.00
RESIN-1 SURFACE	30.00	30.00	0.00
RESIN-2 SURFACES	45.00	45.00	0.00
RESIN-3 SURFACES	55.00	55.00	0.00
RESIN-4 OR MORE SURFACES	55.00	55.00	0.00
CROWN-PORCELAIN WITH METAL	350.00	350.00	0.00
CROWN-3/4 OR FULL CAST	250.00	250.00	0.00
RECEMENT INLAY OR CROWN	15.00	15.00	0.00
PREFAB SS CROWN-PRIMARY	50.00	50.00	0.00
PROVISIONAL CROWN	15.00	15.00	0.00
CAST POST AND CORE	75.00	75.00	0.00
PREFAB POST AND CORE	75.00	75.00	0.00
IV-ENDODONTICS			
ROOT CANAL THERAPY-1 CANAL	250.00	250.00	0.00
ROOT CANAL THERAPY-2 CANALS	300.00	300.00	0.00
ROOT CANAL THERAPY-3 CANALS	400.00	400.00	0.00
RETREAT RCT - 1 CANAL	250.00	250.00	0.00
RETREAT RCT - 2 CANALS	335.00	335.00	0.00
RETREAT RCT - 3 CANALS	430.00	430.00	0.00
APICOECTOMY-bicuspid-first root	300.00	300.00	0.00
APICOECTOMY-each additional	75.00	75.00	0.00
APICOECTOMY-molar-first root	385.00	385.00	0.00
APICOECTOMY-each additional	35.00	35.00	0.00
RETROGRADE FILLING-PER ROOT	50.00	50.00	0.00
ROOT RESECTION/HEMISECTION	85.00	85.00	0.00
V-PERIODONTICS			
GINGIVECTOMY	50.00	50.00	0.00
OSSEOUS SURGERY-PER QUAD	350.00	225.00	125.00
FULL MOUTH DEBRIDEMENT	40.00	40.00	0.00
SCALE & ROOT PLANE-PER QUAD	20.00	0.00	20.00
PERIODONTAL MAINTENANCE	60.00	60.00	0.00

PROCEDURE	MAXIMUM CHARGE	PLAN PAYS	MEMBER PAYS
VI-PROSTHODONTICS			
COMPLETE OR IMMEDIATE DENTURE	300.00	300.00	0.00
PARTIAL DENTURE-ACRYLIC BASE	350.00	350.00	0.00
PARTIAL DENTURE-CAST BASE	500.00	500.00	0.00
REPAIR COMP DENT BASE	40.00	40.00	0.00
REPLC MISS/BRKN TTH-COM DENT	30.00	30.00	0.00
REPAIR PART ACRYLIC SADDLE/BASE	40.00	40.00	0.00
REPAIR CAST FRAMEWORK	40.00	40.00	0.00
REPAIR OR REPLACE BROKEN CLASP	30.00	30.00	0.00
REPLACE BROKEN TEETH- PER TOOTH	30.00	30.00	0.00
RELINE COMPLETE DENTURE-LAB	80.00	80.00	0.00
RELINE PARTIAL DENTURE-LAB	75.00	75.00	0.00
PONTIC-PORCELAIN TO METAL	325.00	325.00	0.00
ABUTMENT-PORCELAIN WITH METAL	350.00	350.00	0.00
ABUTMENT-FULL CAST	250.00	250.00	0.00
RECEMENT BRIDGE	15.00	15.00	0.00
REPLACE FACING	25.00	25.00	0.00
VII-ORAL SURGERY			
SIMPLE EXTRACTION	55.00	55.00	0.00
SURGICAL EXTRACTION	100.00	100.00	0.00
IMPACTION-SOFT TISSUE	225.00	225.00	0.00
IMPACTION-PARTIAL BONY	280.00	280.00	0.00
IMPACTION-COMPLETE BONY	370.00	370.00	0.00
BIOPSY OF ORAL TISSUE	50.00	50.00	0.00
ALVEOPLASTY-WITH EXT, PER QUAD	50.00	50.00	0.00
CYST REMOVAL < 1.25CM	25.00	25.00	0.00
CYST REMOVAL > 1.25CM.	25.00	25.00	0.00
REMOVAL OF EXOSTOSIS	65.00	65.00	0.00
INCISION & DRAINAGE INTRAORAL	25.00	25.00	0.00
FRENULECTOMY	40.00	40.00	0.00
EXCISION OF HYPERPLASIC TISSUE	100.00	100.00	0.00
VIII-ADJUNCTIVE SERVICES			
PALLIATIVE-EMERGENCY TRT	25.00	25.00	0.00
IV CONCIOUS SEDATION - first 30 minutes	40.00	40.00	0.00
CONSULTATION BY SPECIALIST	35.00	35.00	0.00
BRUXISM APPLIANCE	150.00	150.00	0.00
IX-ORTHODONTIC SERVICES			
DIAGNOSIS INCLUDING MODELS	100.00	100.00	0.00
FIXED APPLIANCE	400.00	400.00	0.00
ACTIVE TREATMENT, PER MONTH	70.00	70.00	0.00
RETAINER	150.00	150.00	0.00