BRICKLAYERS INSURANCE AND WELFARE FUND, LOCAL 1
METRODENT PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE FOR *PLAN A* MEMBERS

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 Bricklayers Insurance and Welfare Fund Summary Plan Description. • **Eligible dependents** include spouses, unmarried children who have not yet attained their 19th birthday or 26th birthday if attending an accredited school or college on a full-time basis. • To confirm eligibility you m ay cal Self-Insured Dental Services at (516) 396-5568
PLAN YEAR	• April 1 st through March 31 st
ANNUAL MAXIMUM	• $3,250 annual maximum per covered individual, per plan year which excludes orthodontic services.
DEDUCTIBLE	• There is no annual deductible.
PLAN LIMITATIONS	• **Examination** – two per plan year • **Prophylaxis** – two per plan year • **X-rays** – **panoramic or full mouth series –** $80 maximum per plan year, full mouth series or panorex once per plan year • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored permanent posterior teeth, to age 19, once per lifetime • **Fluoride treatment** – to age 19, maximum one application per plan year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – one per three months. $240 maximum in a calendar year. • **Orthodontic treatment –** $1,940 per covered dependent child up to age 17, $2,100 maximum charge per case, 24 months of active treatment • **Specialist consultation –** one per year, includes 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 charges for deductibles, plan maximums or frequency limitations.
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. 101 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

BRICKLAYERS INSURANCE AND WELFARE FUND. LOCAL 1
SCHEDULE OF ALLOWANCES - PLAN A

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	21.00
FULL MOUTH SERIES X-RAYS or PANORAMIC FILM	40.00
PA OR BW EACH FILM	5.00
OCCLUSAL FILM	10.00
POSTERIOR-ANTERIOR or LATERAL FILM	25.00
CEPHALOMETRIC FILM	34.00
EXTRAORAL or TEMPOROMANDIBULAR FILM	25.00
II-PREVENTIVE	
PROPHYLAXIS-Adult	30.00
PROPHYLAXIS-Child	25.00
FLUORIDE EXCL. PROPHY	10.00
SEALANT-to age 19	20.00
SPACE MAINTAINERS	150.00
III-RESTORATIVE	
AMALGAM - 1 Surface	50.00
AMALGAM - 2 Surface	60.00
AMALGAM - 3 or more surfaces	80.00
RESIN-1 SURFACE-Anterior or Posterior	55.00
RESIN-2 SURFACE-Anterior or Posterior	65.00
RESIN-3 SURFACE-Anterior or Posterior	75.00
INCISAL ANGLE - 4 plus surfaces including incisal	85.00
METALLIC INLAY-1 SRF	190.00
METALLIC INLAY-2 SRF	230.00
METALLIC INLAY-3 SRF	260.00
ONLAY	40.00
PORCELAIN INLAY-1 SRF	190.00
PORCELAIN INLAY-2 SRF	230.00
PORCELAIN INLAY-3 SRF	260.00
CROWN-PLASTIC TO METAL	325.00
CROWN-PORCELAIN	350.00
CROWN-PORCELAIN TO METAL	375.00
CROWN-FULL OR 3/4 CAST	350.00
CAST POST AND CORE	150.00
PREFAB POST AND CORE	100.00
PIN SUPPORT PER TOOTH	25.00
RECEMENT CROWN, INLAY OR BRIDGE	30.00
PREFAB SS CROWN-primary teeth only	75.00
IV-ENDODONTICS	
PULP CAP-DIRECT	20.00
VITAL PULPOTOMY	60.00
ROOT CANAL THERAPY-1 CANAL	225.00
ROOT CANAL THERAPY-2 CANALS	300.00
ROOT CANAL THERAPY-3 CANALS	375.00
ROOT CANAL THERAPY-4+ CANALS	412.00
RETROGRADE FILLING	85.00
APICOECTOMY-first root	130.00
APICOECTOMY-max per tooth	260.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT-no other treatment	30.00
GENERAL ANESTHESIA/IV SEDATION	
Plan pays first 30 minutes only	125.00
SPECIALIST CONSULTATION	50.00

	MAXIMUM CHARGE
VI-PERIODONTICS	
GINGIVECTOMY-PER QUAD	100.00
OSSEOUS SURGERY-PER QUAD	350.00
FREE SOFT TISSUE GRAFTS-PER QUAD	250.00
OSSEOUS GRAFT-MAXIMUM PER QUAD	250.00
OSSEOUS GRAFT-SINGLE SITE	90.00
PEDICLE SOFT TISSUE GRAFT	200.00
CURETTAGE, SCALE\ROOT PLANING-per visit	60.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	55.00
SURGICAL EXTRACTION	100.00
IMPACTION-SOFT TISSUE	125.00
IMPACTION-PARTIAL BONY	175.00
IMPACTION-COMPLETE BONY	225.00
BIOPSY OF ORAL TISSUE	75.00
ALVEOPLASTY-PER JAW	125.00
REMOVAL OF CYST OR TUMOR-<1.25 CM	75.00
REMOVAL OF CYST OR TUMOR->1.25 CM	125.00
HEMISECTION/ROOT RESECTION	105.00
FRENULECTOMY	95.00
INCISION AND DRAINAGE-NO OTHER TREATMENT	50.00
VIII-PROSTHODONTICS	
COMPLETE OR IMMEDIATE DENTURE	600.00
PARTIAL DENTURE-ACRYLIC BASE	225.00
PARTIAL DENTURE-CAST BASE	600.00
UNILATERAL PARTIAL DENTURE	150.00
DENTURE ADJUSTMENT	25.00
REPAIR COMP DENT BASE	90.00
REPAIR CAST FRAMEWORK	100.00
REPLC MISS/BRKN TTH-COM DENT	85.00
RELINE COMPLETE DENTURE-CHAIR	75.00
RELINE PARTIAL DENTURE-CHAIR	75.00
RELINE PARTIAL DENTURE-LABORATORY	100.00
RELINE COMPLETE DENTURE-LABORATORY	125.00
PONTIC-CAST METAL	350.00
PONTIC-PORCELAIN TO METAL	375.00
PONTIC-RESIN WITH METAL	325.00
ABUTMENT CROWN-PLASTIC WITH METAL	325.00
ABUTMENT CROWN-PORCELAIN WITH METAL	375.00
ABUTMENT CROWN-FULL CAST	350.00
REPLACE FACING	100.00
IX-ORTHODONTICS	
INITIAL FIXED APPLIANCE	500.00
ACTIVE TREATMENT-PER MONTH-24 month max	60.00
X-DISCOUNTED ORTHODONTIC SERVICES	
POSTTREATMENT STABILIZATION-PER RETAINER	120.00
PASSIVE TREATMENT-PER THREE MONTHS	60.00
HARMFUL HABIT APPLIANCE	270.00

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