BRICKLAYERS INSURANCE AND WELFARE FUND, LOCAL 1
METRODENT PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE FOR *PLAN B* 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	• $2,450 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 • **Orthodontic treatment –** $1,020 per covered dependent child, $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. 102 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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BRICKLAYERS - PLAN B
SCHEDULE OF ALLOWANCES

PROCEDURE	MAXIMUM CHARGE	PLAN PAYS	MEMBER PAYS
I-DIAGNOSTIC			
ORAL EXAM	21.00	21.00	0.00
FULL MOUTH OR PANOREX	40.00	40.00	0.00
PERIAPICAL OR BITEWING (@ FILM)	5.00	5.00	0.00
OCCLUSAL FILM	10.00	10.00	0.00
EXTRAORAL OR TMJ FILM (@ FILM)	25.00	25.00	0.00
POSTERIOR-ANTERIOR LATERAL	25.00	25.00	0.00
CEPHALOMETRIC FILM	34.00	34.00	0.00
II-PREVENTIVE			
PROPHYLAXIS- ADULT	30.00	30.00	0.00
PROPHYLAXIS- CHILD	25.00	25.00	0.00
FLUORIDE EXCL. PROPHY	10.00	10.00	0.00
SEALANT	20.00	20.00	0.00
SPACE MAINTAINERS	150.00	150.00	0.00
III-RESTORATIVE			
AMALGAM - 1 SURFACE	50.00	35.00	15.00
AMALGAM - 2 SURFACES	60.00	45.00	15.00
AMALGAM - 3 SURFACES	80.00	65.00	15.00
AMALGAM - 4 OR MORE SURFACES	80.00	65.00	15.00
RESIN-1 SURFACE	55.00	35.00	20.00
RESIN-2 SURFACES	65.00	45.00	20.00
RESIN-3 SURFACES	85.00	65.00	20.00
RESIN-4 OR MORE SURFACES	85.00	65.00	20.00
METALIC INLAY-1 SRF	190.00	30.00	160.00
METALIC INLAY-2 SRF	230.00	70.00	160.00
METALIC INLAY-3 SRF	260.00	100.00	160.00
ONLAY-METALIC	40.00	40.00	0.00
PORCELAIN INLAY-1 SRF	190.00	30.00	160.00
PORCELAIN INLAY-2 SRF	230.00	70.00	160.00
PORCELAIN INLAY-3 SRF	260.00	100.00	160.00
CROWN-RESIN WITH METAL	325.00	165.00	160.00
CROWN-PORCELAIN	350.00	190.00	160.00
CROWN-PORCELAIN WITH METAL	375.00	215.00	160.00
CROWN-3/4 OR FULL CAST	350.00	190.00	160.00
RECEMENT INLAY OR CROWN	30.00	25.00	5.00
PREFAB SS CROWN-PRIMARY	75.00	75.00	0.00
PIN RETENTION-PER TOOTH	25.00	15.00	10.00
CAST POST AND CORE	150.00	125.00	25.00
PREFAB POST AND CORE	100.00	75.00	25.00
LABIAL VENEER, LABRATORY	215.00	55.00	160.00
IV-ENDODONTICS			
PULP CAP-DIRECT	20.00	20.00	0.00
ROOT CANAL THERAPY-1 CANAL	225.00	140.00	85.00
ROOT CANAL THERAPY-2 CANALS	300.00	190.00	110.00
ROOT CANAL THERAPY-3 CANALS	375.00	265.00	110.00
ROOT CANAL THERAPY-4 CANALS	412.00	302.00	110.00
APICOECTOMY-PER ROOT	130.00	130.00	0.00
APICOECTOMY-maximum per tooth	260.00	260.00	0.00
RETROGRADE FILLING-PER ROOT	85.00	60.00	25.00
V-PERIODONTICS			
GINGIVECTOMY	100.00	100.00	0.00
OSSEOUS SURGERY-PER QUAD	350.00	275.00	75.00
OSSEOUS GRAFT-SINGLE SITE	90.00	90.00	0.00
OSSEOUS GRAFT-MULTIPLE SITE	250.00	225.00	25.00
PEDICLE SOFT TISSUE GRAFT	250.00	150.00	100.00
FREE SOFT TISSUE GRAFT	200.00	150.00	50.00
SCALE & ROOT PLANE-PER VISIT	60.00	25.00	35.00
PERIODONTAL MAINTENANCE	60.00	25.00	35.00

PROCEDURE	MAXIMUM CHARGE	PLAN PAYS	MEMBER PAYS
VI-PROSTHODONTICS			
COMPLETE OR IMMEDIATE DENTURE	600.00	285.00	315.00
PARTIAL DENTURE-ACRYLIC BASE	225.00	200.00	25.00
PARTIAL DENTURE-CAST BASE	600.00	285.00	315.00
UNILATERAL PARTIAL DENTURE	150.00	100.00	50.00
REPAIR COMP DENT BASE	90.00	30.00	60.00
REPLC MISS/BRKN TTH-COM DENT	85.00	55.00	30.00
REPAIR PART ACRYLIC SADDLE/BASE	90.00	35.00	55.00
REPAIR CAST FRAMEWORK	100.00	45.00	55.00
REPAIR OR REPLACE BROKEN CLASP	75.00	35.00	40.00
REPLACE BROKEN TEETH- PER TOOTH	85.00	55.00	30.00
RELINE COMPLETE DENTURE-CHAIR	75.00	50.00	25.00
RELINE PARTIAL DENTURE-CHAIR	75.00	50.00	25.00
RELINE COMPLETE DENTURE-LAB	125.00	100.00	25.00
RELINE PARTIAL DENTURE-LAB	100.00	75.00	25.00
TISSUE CONDITIONING	40.00	40.00	0.00
PONTIC-CAST METAL	350.00	190.00	160.00
PONTIC-PORCELAIN TO METAL	375.00	190.00	185.00
PONTIC-RESIN WITH METAL	325.00	190.00	135.00
ABUTMENT-RESIN WITH METAL	325.00	190.00	135.00
ABUTMENT-PORCELAIN WITH METAL	375.00	190.00	185.00
ABUTMENT-FULL CAST	350.00	190.00	160.00
RECEMENT BRIDGE	30.00	25.00	5.00
REPLACE FACING	100.00	50.00	50.00
VII-ORAL SURGERY			
SIMPLE EXTRACTION	55.00	30.00	25.00
SURGICAL EXTRACTION	100.00	70.00	30.00
IMPACTION-SOFT TISSUE	125.00	85.00	40.00
IMPACTION-PARTIAL BONY	175.00	100.00	75.00
IMPACTION-COMPLETE BONY	225.00	135.00	90.00
BIOPSY OF ORAL TISSUE	75.00	60.00	15.00
ALVEOPLASTY-WITH EXT, PER QUAD	125.00	75.00	50.00
CYST REMOVAL < 1.25CM	75.00	50.00	25.00
CYST REMOVAL > 1.25CM.	125.00	100.00	25.00
INCISION & DRAINAGE INTRAORAL	50.00	50.00	0.00
FRENULECTOMY	95.00	70.00	25.00
VIII-ADJUNCTIVE SERVICES			
PALLIATIVE-EMERGENCY TRT	30.00	30.00	0.00
GENERAL ANESTHESIA-plan pays 1st 30 minutes	125.00	60.00	65.00
CONSULTATION BY SPECIALIST	50.00	50.00	0.00
IX-ORTHODONTIC SERVICES			
COMPREHENSIVE TREATMENT			
FIXED APPLIANCE	500.00	300.00	200.00
ACTIVE TREATMENT, PER MONTH	60.00	30.00	30.00
X-DISCOUNTED ORTHODONITC SERVICES			
HARMFUL HABIT APPLIANCE	270.00	0.00	270.00
PASSIVE TREATMENT, PER 3 MONTHS	60.00	0.00	60.00
POST-TREATMENT STABILIZATION DEVICE	120.00	0.00	120.00