

**Self-Insured Dental Services / Administrative Services Only, Inc.      Dental Plan Administrators**  
**POINTERS, CLEANERS & CAULKERS WELFARE FUND**  
**METRODENT 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.

<b>ELIGIBILITY</b>	<ul style="list-style-type: none"> <li>Eligibility is determined according to the definition and requirements outlined in the Pointers, Cleaners &amp; Caulkers Welfare Fund Summary Plan Description. To confirm eligibility you may call Self-Insured Dental Services at (516) 396-5568.</li> <li><b>Eligible dependents</b> include the lawful spouse and each unmarried dependent child from birth until the last day of the calendar year in which the child reaches age 19. Dependent children attending an accredited school or college on a full-time basis are eligible up until the child reaches age 26 or graduates, whichever comes first.</li> </ul>
<b>PLAN YEAR</b>	<ul style="list-style-type: none"> <li>January 1 st through December 31 st</li> </ul>
<b>PLAN MAXIMUM</b>	<ul style="list-style-type: none"> <li><b>Mechanics:</b> \$1,500 annual maximum</li> <li><b>1<sup>st</sup> year Apprentice:</b> \$675 annual maximum</li> <li><b>2<sup>nd</sup> year Apprentice:</b> \$1,050 annual maximum</li> <li><b>Retirees:</b> \$700 annual maximum</li> </ul>
<b>DEDUCTIBLE</b>	<ul style="list-style-type: none"> <li>There is no annual deductible</li> </ul>
<b>PLAN LIMITATIONS</b>	<ul style="list-style-type: none"> <li><b>Examination</b> – two per calendar year</li> <li><b>Prophylaxis</b> – two per calendar year</li> <li><b>X-rays</b> – \$80 maximum per calendar year, full mouth series or panorex once per calendar year</li> <li><b>Replacement of crowns, bridge, dentures</b> – not more than once in five years</li> <li><b>Palliative treatment</b> – no other treatment rendered that same visit</li> <li><b>Fluoride treatment</b> – to age 15, one per calendar year</li> <li><b>Sealant</b> – unrestored permanent posterior teeth only, to age 15, once per lifetime</li> <li><b>Root Scaling, curettage, bite correction; any combination, including prophylaxis</b> – one per three months</li> <li><b>Periodontal Maintenance-</b> one per 3 months, \$240 maximum per plan year.</li> <li><b>Orthodontic treatment</b> – maximum lifetime benefit per covered dependent up to age 17 is as follows – Mechanics \$4,000, 1<sup>st</sup> year Apprentice \$1,800 and 2<sup>nd</sup> year Apprentice \$2,800.</li> <li><b>Specialist Consultation</b> – one per calendar year, includes examination</li> </ul>
<b>PRE-TREATMENT REVIEW</b>	<ul style="list-style-type: none"> <li>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. <b>Please note-</b> a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible</li> <li>Pre-op periapical x-rays required for crowns, veneers, inlays and extractions</li> <li>Periodontal charting and x-rays are required for surgical periodontal procedures</li> <li>Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework</li> </ul>
<b>PERMISSIBLE CHARGES</b>	<ul style="list-style-type: none"> <li><b>Covered and reimbursable services:</b> None</li> <li><b>Covered but not reimbursable services:</b> Schedule allowance</li> <li><b>Non-covered services:</b> Your usual charge for that service</li> </ul>
<b>COORDINATION OF BENEFITS</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>HOW TO FILE A CLAIM</b>	<ul style="list-style-type: none"> <li><b>As a participating provider, you must complete all necessary paper work and accept assignment of benefits.</b></li> <li>Complete a Claim Form (<b>computer generated, ADA, and universal claim forms are accepted</b>) and provide an itemized bill of services rendered. <b>Signature on file is accepted.</b></li> <li>Enclose, when appropriate, x-rays, tooth charting, periodontal charting</li> <li>Mail claims to : Self-Insured Dental Services, Dept 109 P.O. Box 9005 Lynbrook, NY 11563</li> <li>File claims electronically: <b>PAYOR ID: CX076</b></li> </ul>

For up to date detailed information, including member eligibility, please access our website at:

[www.asonet.com](http://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

POINTERS, CLEANERS & CAULKERS WELFARE FUND  
SCHEDULE OF ALLOWANCES FOR PLAN A MEMBERS

	MAXIMUM CHARGE		MAXIMUM CHARGE
<u>I-DIAGNOSTIC</u>		<u>VI-PERIODONTICS</u>	
ORAL EXAM	21.00	GINGIVECTOMY-PER QUAD	100.00
FULL MOUTH SERIES X-RAYS or PANORAMIC FILM	40.00	OSSEOUS SURGERY-PER QUAD	350.00
PA OR BW EACH FILM	5.00	FREE SOFT TISSUE GRAFTS-PER QUAD	250.00
OCCLUSAL FILM	10.00	OSSEOUS GRAFT-MAXIMUM PER QUAD	250.00
POSTERIOR-ANTERIOR or LATERAL FILM	25.00	OSSEOUS GRAFT-SINGLE SITE	90.00
CEPHALOMETRIC FILM	34.00	PEDICLE SOFT TISSUE GRAFT	200.00
EXTRAORAL or TEMPOROMANDIBULAR FILM	25.00	CURETTAGE, SCALE/ROOT PLANING-per visit	60.00
		PERIODONTAL MAINTENANCE PROCEDURE	60.00
<u>II-PREVENTIVE</u>		<u>VII-ORAL SURGERY</u>	
PROPHYLAXIS-Adult	30.00	SIMPLE EXTRACTION	55.00
PROPHYLAXIS-Child	25.00	SURGICAL EXTRACTION	100.00
FLUORIDE EXCL. PROPHY	10.00	IMPACTION-SOFT TISSUE	125.00
SEALANT-to age 15	20.00	IMPACTION-PARTIAL BONY	175.00
		IMPACTION-COMPLETE BONY	225.00
<u>III-RESTORATIVE</u>		BIOPSY OF ORAL TISSUE	75.00
AMALGAM - 1 Surface	50.00	ALVEOPLASTY-PER JAW	125.00
AMALGAM - 2 Surface	60.00	REMOVAL OF CYST OR TUMOR-<1.25 CM	75.00
AMALGAM - 3 or more surfaces	80.00	REMOVAL OF CYST OR TUMOR->1.25 CM	125.00
RESIN-1 SURFACE-Anterior or Posterior	55.00	HEMISECTION/ROOT RESECTION	105.00
RESIN-2 SURFACE-Anterior or Posterior	65.00	FRENULCTOMY	95.00
RESIN-3 SURFACE-Anterior or Posterior	75.00	INCISION AND DRAINAGE-NO OTHER TREATMI	50.00
INCISAL ANGLE - 4 plus surfaces including incisal	85.00		
METALLIC INLAY-1 SRF	190.00	<u>VIII-PROSTHODONTICS</u>	
METALLIC INLAY-2 SRF	230.00	COMPLETE OR IMMEDIATE DENTURE	600.00
METALLIC INLAY-3 SRF	260.00	PARTIAL DENTURE-ACRYLIC BASE	225.00
ONLAY	40.00	PARTIAL DENTURE-CAST BASE	600.00
PORCELAIN INLAY-1 SRF	190.00	UNILATERAL PARTIAL DENTURE	150.00
PORCELAIN INLAY-2 SRF	230.00	DENTURE ADJUSTMENT	25.00
PORCELAIN INLAY-3 SRF	260.00	REPAIR COMP DENT BASE	90.00
CROWN-PLASTIC TO METAL	325.00	REPAIR CAST FRAMEWORK	100.00
CROWN-PORCELAIN	350.00	REPLC MISS/BRKN WITH-COM DENT	85.00
CROWN-PORCELAIN TO METAL	375.00	RELINE COMPLETE DENTURE-CHAIR	75.00
CROWN-FULL OR 3/4 CAST	350.00	RELINE PARTIAL DENTURE-CHAIR	75.00
CAST POST AND CORE	150.00	RELINE PARTIAL DENTURE-LABORATORY	100.00
PREFAB POST AND CORE	100.00	RELINE COMPLETE DENTURE-LABORATORY	125.00
PIN SUPPORT PER TOOTH	25.00	PONTIC-CAST METAL	350.00
RECEMENT CROWN, INLAY OR BRIDGE	30.00	PONTIC-PORCELAIN TO METAL	375.00
PREFAB SS CROWN-primary teeth only	75.00	PONTIC-RESIN WITH METAL	325.00
		ABUTMENT CROWN-PLASTIC WITH METAL	325.00
<u>IV-ENDODONTICS</u>		ABUTMENT CROWN-PORCELAIN WITH METAL	375.00
PULP CAP-DIRECT	20.00	ABUTMENT CROWN-FULL CAST	350.00
VITAL PULPOTOMY	60.00	REPLACE FACING	100.00
ROOT CANAL THERAPY-Anterior	225.00		
ROOT CANAL THERAPY-Bicuspid	300.00	<u>IX-ORTHODONTICS</u>	
ROOT CANAL THERAPY-Molar	375.00	INITIAL FIXED APPLIANCE	500.00
RETROGRADE FILLING	85.00	ACTIVE TREATMENT-PER MONTH-24 month ma	60.00
APICOECTOMY-first root	130.00	POST TREATMENT STABILIZATION-PER REPAIR	120.00
APICOECTOMY-max per tooth	260.00	PASSIVE TREATMENT-PER THREE MONTHS	60.00
		HARMFUL HABIT APPLIANCE	270.00
<u>V-ADJUNCTIVE SERVICES</u>			
PALLIATIVE TREATMENT-no other treatment	30.00		
GENERAL ANESTHESIA/IV SEDATION	125.00		
Plan pays first 30 minutes only			
SPECIALIST CONSULTATION	50.00		