CIVIL SERVICE EMPLOYEES LOCAL 1969 WELFARE FUND
LOCAL 1969/METRODENT PREMIER 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	• All active painters employed under a Local 1969 Collective Bargaining Agreement by the City of New York, from the first day of the month in which the fund received the first quarterly contributions from the City on the members' behalf, are eligible for dental benefits. Retirees covered under such Agreement and for whom the plan receives contributions are also eligible. • **Eligible dependents** – Include the lawful spouse and each dependent child from birth until the age of 26 is reached so long as they are not covered by or eligible for other health insurance through their employer and have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
PLAN YEAR	• January 1 through December 31
PLAN MAXIMUM	• $2,000 per covered individual in a calendar year
DEDUCTIBLE	• There is no plan deductible
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Palliative treatment** – no other treatment rendered that same visit • **Replacement of crowns, bridges and dentures –** not more than once in 5 years • **Fluoride treatment** – to age 15, one application per year • **Sealant –** to age 19, permanent posterior teeth, 1 per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $180 per calendar year • **Orthodontic treatment –** 12 Interceptive months, 24 Active months and 3 Passive months • **Specialist Consultation –** one per calendar year, includes allowance for 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, no co-payment:** None • **Covered and reimbursable services, with co-payment:** only established co-payment • **Covered but not reimbursable services:** Schedule allowance plus established co-payments • **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 co-payments, deductibles, or charges due to maximums or 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: ASO, Dept 35. 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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CIVIL SERVICE PAINTERS LOCAL 1969
SCHEDULE OF ALLOWANCE

I-DIAGNOSTIC	MAXIMUM CHARGE	MEMBER COPAYMENT
ORAL EXAM	17.00	
X-RAYS (FULL MOUTH SERIES)	40.00	
INTRAORAL X-RAY (EACH FILM)	5.00	
OCCLUSAL FILM	10.00	
PANORAMIC FILM	40.00	
CEPHALOMETRIC FILM	40.00	
II-PREVENTIVE		
PROPHYLAXIS-ADULT	30.00	
PROPHYLAXIS-CHILD	25.00	
FLOURIDE EXCL. PROPHY	10.00	
SEALANT-PER TOOTH	15.00	
SPACE MAINTAINER	150.00	
III-RESTORATIVE		
AMALGAM - 1 SURFACE	45.00	
AMALGAM - 2 SURFACE	55.00	
AMALGAM - 3 SURFACE	60.00	
AMALGAM - 4OR MORE SURFACES	65.00	
RESIN-1 SURFACE	52.00	
RESIN-2 SURFACE	60.00	
RESIN-3 SURFACE	70.00	
RESIN-INCISAL ANGLE	80.00	
METALLIC INLAY-1 SRF	200.00	
METALLIC INLAY-2 SRF	230.00	
METALLIC INLAY-3 SRF	260.00	
METALLIC ONLAY-IN ADDITION TO INLAY	70.00	
CROWN PLASTIC-LAB ONLY	175.00	
CROWN-PLASTIC WITH METAL	300.00	75.00
CROWN-PORCELAIN	275.00	75.00
CROWN-PORCELAIN WITH METAL	350.00	75.00
GOLD FULL CAST CROWN	275.00	75.00
CROWN-3/4 CAST	275.00	75.00
RECEMENT CROWN OR INLAY	30.00	
PREFAB SS CROWN-PRIMARY	75.00	
PIN RETENTION-PER TOOTH	25.00	
CAST POST AND CORE	125.00	
PREFAB POST AND CORE	75.00	
LABIAL VENEER-LAB PROC	275.00	
IV-ENDODONTICS		
PULP CAP	10.00	
VITAL PULPOTOMY	60.00	
ROOT CANAL THERAPY-Anterior	225.00	
ROOT CANAL THERAPY-Biscuspid	275.00	
ROOT CANAL THERAPY-Molar	350.00	
APICOECTOMY-PER ROOT	150.00	
APICO-MAXIMUM PER TOOTH	300.00	
RETROGRADE FILLING	85.00	
V-PERIODONTICS		
GINGIVECTOMY-PER QUADRANT	110.00	
OSSEOUS SURGERY-PER QUAD	350.00	
OSSEOUS GRAFT-SINGLE SITE	90.00	
OSSEOUS GRAFT-MULTIPLE SITE	250.00	
PERIO SCALE-FULL MOUTH	60.00	
PERIO SCALE-PER VISIT	50.00	
PERIO PROPHY	60.00	

VI-PROSTHODONTICS	MAXIMUM CHARGE	MEMBER COPAYMENT
DENTURE-PERMANENT OR IMMEDIATE	600.00	
PARTIAL DENTURE-ACRYLIC BASE	425.00	
PARTIAL DENTURE-CAST BASE	600.00	
UNILATERAL PARTIAL DENTURE	200.00	
REPAIR COMP DENT BASE	90.00	
REPLC MISS/BRKN TTH-COM DENT	85.00	
REPAIR PART ACRYLIC SADDLE/BASE	90.00	
REPAIR CAST FRAMEWORK	100.00	
REPAIR OR REPLACE BROKEN CLASP	85.00	
REPLACE BROKEN TOOTH	85.00	
REPLACE BROKEN FACING	100.00	
ADD CLASP TO EXISTING PART DENT	85.00	
RELINE COMPLETE DENTURE-CHAIR	80.00	
RELINE PARTIAL DENTURE-CHAIR	75.00	
RELINE COMPLETE DENTURE-LAB	125.00	
RELINE PARTIAL DENTURE-LAB	100.00	
INLAY-TWO SURFACE	230.00	
INLAY-THREE SURFACE	260.00	
PONTIC-FULL CAST	275.00	75.00
PONTIC-PORCELAIN TO METAL	350.00	75.00
PONTIC-RESIN WITH METAL	300.00	75.00
CAST METL RETNR-ACID ETCH BRIDGE	230.00	
CROWN-PLASTIC WITH METAL	300.00	75.00
CROWN-3/4 CAST	275.00	75.00
CROWN-PORCELAIN WITH METAL	350.00	75.00
CROWN-FULL CAST	275.00	75.00
RECEMENT BRIDGE	40.00	
PRECISION ATTACHMENT	125.00	
VII-ORAL SURGERY		
SIMPLE EXTRACTION	50.00	
SURGICAL EXTRACTION	75.00	
IMPACTION-SOFT TISSUE	115.00	
IMPACTION-PARTIAL BONY	185.00	
IMPACTION-COMPLETE BONY	225.00	
SURGICAL ROOT RECOVERY	90.00	
SURGICAL EXPOSURE IMPACTED OR UNERUPTED TOOTH	80.00	
BIOPSY OF ORAL TISSUE	75.00	
ALVEOPLASTY-PER QUAD	125.00	
CYST REMOVAL < 1.25CM	75.00	
CYST REMOVAL > 1.25CM.	125.00	
INCISION & DRAINAGE INTRAORAL	50.00	
FRENULECTOMY	95.00	
ROOT RESECTION	150.00	
HEMISECTION	150.00	
VIII-ORTHODONTICS		
INITIAL APPLICANCE-INCL DIAGNOSIS	480.00	
ACTIVE TREATMENT-PER MONTH	60.00	
PASSIVE TREATMENT- PER 3 MONTHS	60.00	
HARMFUL HABIT APPLIANCE	270.00	
RETENTION APPLIANCE	120.00	
IX-ADJUNCTIVE SERVICES		
PALLIATIVE TREATMENT	30.00	
SPECIALIST CONSULTATION	50.00	
GENERAL ANESTHESIA-plan pays first 30 minutes only	125.00	