SHOPMEN IRON WORKERS WELFARE FUND
METRODENT PREMIER PLUS 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	• **Eligible dependents** include lawful spouses and each unmarried child who has not attained their 26th birthday.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $1,500 per covered individual in a calendar year
DEDUCTIBLE	• $50 per individual, up to $150.00 per family per calendar year
PLAN LIMITATIONS	• **Examination** –two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic and full mouth series –** once each in thirty six months • **Extraoral / TMJ film** – one in any twelve month period • **Periapical or bitewing film** – maximum 8 in six months • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 16, maximum two applications per year • **Sealant –** unrestored permanent posterior teeth, to age 16, maximum one application per tooth, per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $100 per visit, maximum visits 1 every 3 months, $400 in a calendar year. • **Orthodontic treatment –** 24 months active treatment, 18 months passive treatment, $1,000 lifetime maximum per dependent child. Once the maximum is reached, the patient is responsible to pay the Orthodontist directly according to the Schedule of Maximum Charges. • **Replacement of crowns, bridge and dentures –** not more than once in five years • **Denture adjustment –** one per calendar year, after first year of insertion • **Specialist Consultation –** one in a 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, no co-payment:** Schedule allowance • **Covered but not reimbursable services, with co-payment:** scheduled 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 your usual charge.
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 and provide an itemized bill of services rendered. • **File Claims Electronically PAYOR ID CX076** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting Mail claims to: ASO, INC Dept 26 PO Box 9005 Lynbrook, NY 11563 516-396-5500/800-537-1238

For up to date detailed information please access our website at:
www.asonet.com
If you have any questions regarding the operation of this program please contact ASO. at:
(516) 396-5500 or (718) 204-7172

Rev 08/22

SHOPMEN IRON WORKERS
SCHEDULE OF MAXIMUM

	MAXIMUM CHARGE	PLAN PAYS	MEMBER CO-PAY
I- DIAGNOSTIC & PREVENTIVE			
ORAL EXAM	43.00	43.00	0.00
PERIAPICAL - FIRST FILM BITEWING -	14.00	14.00	0.00
FIRST FILM	15.00	15.00	0.00
EACH ADDITIONAL PA OR BITEWING	12.00	12.00	0.00
OCCLUSAL FILM	21.00	21.00	0.00
FULL MOUTH X-RAY	100.00	100.00	0.00
PANORAMIC FILM	61.00	61.00	0.00
EXTRA ORAL or TMJ FILM	30.00	30.00	0.00
PROPHYLAXIS-ADULT	50.00	50.00	0.00
PROPHYLAXIS-CHILD	36.00	36.00	0.00
SEALANT	28.00	28.00	0.00
FLUORIDE EXCL PROPHY	22.00	22.00	0.00
SPACE MAINTAINER	179.00	179.00	0.00
II- RESTORATIVE			
AMALGAM-1 SRF	66.00	66.00	0.00
AMALGAM-2 SRF	86.00	86.00	0.00
AMALGAM-3 SRF	103.00	103.00	0.00
AMALGAM-4 SRF	126.00	126.00	0.00
RESIN-1 SURFACE	77.00	77.00	0.00
RESIN-2 SURFACE	99.00	99.00	0.00
RESIN-3+ SURFACE	122.00	122.00	0.00
RESIN-INCISAL ANGLE	142.00	142.00	0.00
CROWN-ACRYLIC JACKET	227.00	127.00	100.00
CROWN-PORCELAIN JACKET	639.00	474.00	165.00
CROWN-PORCELAIN TO METAL	631.00	466.00	165.00
CROWN-RESIN TO METAL	625.00	460.00	165.00
CROWN-FULL or 3/4 CAST	608.00	443.00	165.00
RECEMENT-INLAY or CROWN	52.00	52.00	0.00
RECEMENT BRIDGE	72.00	72.00	0.00
RECEMENT SPACE MAINTAINER	40.00	40.00	0.00
PREFAB SS CROWN-PRIMARY	149.00	149.00	0.00
PIN RETENTION-PER TOOTH	29.00	29.00	0.00
CAST POST AND CORE	216.00	125.00	91.00
PREFAB POST AND CORE	179.00	110.00	69.00
III- ENDODONTICS			
PULP CAP	38.00	38.00	0.00
VITAL PULPOTOMY	65.00	65.00	0.00
ROOT THERAPY-anterior tooth	465.00	415.00	50.00
ROOT THERAPY-bicuspid tooth	527.00	477.00	50.00
ROOT THERAPY-molar tooth	641.00	591.00	50.00
APICOECTOMY-FIRST ROOT	443.00	393.00	50.00
APICOECTOMY-MAX PER TOOTH	883.00	833.00	50.00
RETROGRADE FILLING	150.00	150.00	0.00
ROOT RESECTION	272.00	222.00	50.00
HEMISECTION	212.00	162.00	50.00
IV-ADJUNCTIVE SERVICES			
CONSULTATION	50.00	50.00	0.00
PALLIATIVE TREATMENT	54.00	54.00	0.00
GENERAL ANES-per 15 minutes	87.50	75.00	12.50
EACH ADDITIONAL 15 min max 1 hr	87.50	75.00	12.50
V- PERIODONTICS			
GINGIVECTOMY-PER QUAD	379.00	329.00	50.00
OSSEOUS SURGERY	720.00	570.00	150.00
SCALING & CURETTAGE-VISIT	100.00	100.00	0.00

	MAXIMUM CHARGE	PLAN PAYS	MEMBER CO-PAY
VI-PROSTHODONTICS			
DENT COMPLETE/IMMEDIATE	838.00	673.00	165.00
PARTIAL-ACRYLIC BASE	823.00	673.00	165.00
PARTIAL-CAST METAL BASE	926.00	761.00	165.00
UNILATERAL PARTIAL DENT	540.00	375.00	165.00
PONTIC-PORCELAIN TO METAL	545.00	380.00	165.00
PONTIC-RESIN WITH METAL	538.00	373.00	165.00
PONTIC-CAST METAL	553.00	388.00	165.00
MARYLAND BRIDGE ABUT	315.00	150.00	165.00
DENTURE ADJUSTMENT	46.00	46.00	0.00
RELINE DENTURE, LAB	256.00	256.00	0.00
RELINE DENTURE, OFFICE	176.00	176.00	0.00
PRECISION ATTACHMENT	125.00	125.00	0.00
BROKEN FACING	100.00	100.00	0.00
BROKEN DENTURE BASE	91.00	91.00	0.00
MISS/BKEN TTH IN DENT	85.00	85.00	0.00
RESIN SADDLE or BASE	100.00	100.00	0.00
CAST FRAMEWORK	100.00	100.00	0.00
BROKEN CLASP	130.00	130.00	0.00
REATTACH CLASP	75.00	75.00	0.00
ADD TTH TO EXISTING PART	114.00	114.00	0.00
EACH ADDITIONAL TOOTH	50.00	50.00	0.00
ADD CLASP TO EXIST PART	138.00	138.00	0.00
VII-ORAL SURGERY			
SIMPLE EXTRACTION	85.00	85.00	0.00
SURGICAL EXTRACTION	150.00	150.00	0.00
SURG. EXPOSURE FOR ORTHO	318.00	318.00	0.00
SURG. EXPOSURE AID ERUPTIOI	225.00	225.00	0.00
DEVICE TO AID ERUPTION	75.00	75.00	0.00
IMPACTION-SOFT TISSUE*	170.00	170.00	0.00
IMPACTION-PARTIAL BONY*	250.00	250.00	0.00
IMPACTION-COMPLETE BONY*	350.00	350.00	0.00
BIOPSY*	***	***	***
ALVEOPLASTY-PER JAW	157.00	157.00	0.00
CYST/TUMOR REMOVAL<1.25	460.00	460.00	0.00
CYST/TUMOR REMOVAL>1.25	723.00	723.00	0.00
REMOVAL OF LABIAL FRENUM*	252.00	252.00	0.00
*** Services that are paid as medical expenses**			
VIII-ORTHODONTIC SERVICES			
Lifetime Maximum of $1,000 per dependent child.			
Please refer to Plan Description			
INTERCEPTIVE TREATMENT			
REMOVABLE APPLIANCE	270.00	270.00	0.00
FIXED APPLIANCE	300.00	300.00	0.00
ACTIVE TREATMENT, per month	70.00	70.00	0.00
MAXIMUM CHARGE PER CASE	**780.00**		
REMOVABLE & HARMFUL			
HABIT APPLIANCE	270.00	270.00	0.00
FIXED APPLIANCE	480.00	480.00	0.00
ACTIVE TREATMENT, per month	70.00	70.00	0.00
PASSIVE TREATMENT, per month	70.00	70.00	0.00
STABILIZATION DEVICE	120.00	120.00	0.00
MAXIMUM CHARGE PER CASE	**2,600.00**		

REV 03/22

SHOPMEN IRON WORKERS
DENTAL PLAN

IMPLANT AND IMPLANT RELATED SERVICES: EFFECTIVE 03/22

	Maximum Charge	Plan Pays	Member Pays
Endosteal Implant	$1200.00	$600.00	$600.00
Subperiosteal Implant	$1200.00	$600.00	$600.00
Transosseous Implant	$1200.00	$600.00	$600.00
Interim Abutment	$500.00	$250.00	$250.00
Prefabricated Abutment	$500.00	$250.00	$250.00
Custom Abutment	$500.00	$250.00	$250.00
Abutment Supported Porcelain Ceramic Crown	$750.00	$375.00	$375.00
Abutment Supported Porcelain/Metal Crown	$750.00	$375.00	$375.00
Abutment Supported Crown	$750.00	$375.00	$375.00
Abutment Supported Cast High Noble Metal Crown	$750.00	$375.00	$375.00
Abutment Supported Noble Metal Crown	$750.00	$375.00	$375.00
Implant Supported Porcelain Ceramic Crown	$950.00	$475.00	$475.00
Implant Supported Porcelain/High Noble Metal Crown	$950.00	$475.00	$475.00
Implant Supported High Noble Metal Crown	$950.00	$475.00	$475.00

Maximum 2 implants per arch payable per lifetime. I