STRUCTURAL STEEL & BRIDGE PAINTERS LOCAL 806 WELFARE FUND
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	• Individuals who are in Covered Employment under the provisions of a collective bargaining agreement with the **Structural Steel & Bridge Painters Union of New York City.** Retirees meeting eligibility requirements are also covered. • **Eligible dependents** include spouse and, unmarried dependent children who have not reached their 19th birthday. Coverage is extended until the 26th birthday for unmarried dependent children attending school full-time. Unmarried children incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation, or physical handicap; will continue to be eligible.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $2,000 in a calendar year for Active and Retired Members/Private Sector • $2,000 in a calendar year for Active Members/Civil Service Division • $1,000 in a calendar year for Retired Members/Civil Service Division
DEDUCTIBLE	• There is no annual deductible
PLAN LIMITATIONS	• **Examination** –two per calendar year • **Prophylaxis** – two per calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, one application per year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $120 in a calendar year • **Replacement of crowns, bridges, dentures –** not more than once in 5 years • **Orthodontic treatment –** maximum 24 months active treatment, 9 months passive treatment, $1,450 lifetime maximum for Active & Retired Members/Private Sector and $800 lifetime maximum for Active members/Civil Service Division, per covered individual; not subject to annual maximum. Retirees of the Civil Services Division have no orthodontic benefit payable by the Fund. However, Participating Orthodontists agree to limit their charges to the fees listed in the schedule. Members and their dependents using this program will be responsible to pay these fees directly to the Participating Orthodontist.
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 co-payment if applicable • **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 incurred due to co-payments, plan maximums and 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 : ASO, Dept 43 P.O. Box 9005 Lynbrook, NY 11563 • File claims electronically: **PAYOR ID: CX076**

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 S.I.D.S. at:
(516) 396-5500 or (718) 204-7172

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Administrative Services Only, Inc. **Dental Plan Administrators**

STRUCTURAL STEEL & BRIDGE PAINTERS LOCAL 806
SCHEDULE OF COVERED PROCEDURES &
MAXIMUM PARTICIPATING DENTIST CHARGES

	MAXIMUM CHARGE	
I-DIAGNOSTIC		
ORAL EXAM	17.00	
FULL MOUTH SERIES OR PANORAMIC	40.00	
INTRAORAL X-RAY (EACH FILM)	5.00	
OCCLUSAL FILM	10.00	
CEPHALOMETRIC FILM	40.00	
POSTERIOR-ANTERIOR, LATERAL, TMJ	25.00	
SIALOGRAPHY	40.00	
PULP VITALITY TEST	15.00	
DIAGNOSTIC CASTS	25.00	
PALLIATIVE TREATMENT	30.00	
CONSULTATION BY SPECIALIST	50.00	
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 SRF	45.00	
AMALGAM - 2 SRF	55.00	
AMALGAM - 3 SRF	60.00	
AMALGAM - 4+ SRF	65.00	
RESIN-1 SURFACE	50.00	
RESIN-2 SURFACE	60.00	
RESIN-3 OR MORE SURFACES	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	
ONLAY IN ADDITION TO INLAY	70.00	
PORCELAIN INLAY-1 SRF	200.00	
PORCELAIN INLAY-2 SRF	230.00	
PORCELAIN INLAY-3 SRF	260.00	
CROWN PLASTIC-LAB ONLY	175.00	
CROWN-PLASTIC WITH METAL	375.00	*
CROWN-PORCELAIN	350.00	*
CROWN-PORCELAIN WITH METAL	425.00	*
CROWN- FULL OR 3/4 CAST	350.00	*
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	250.00	
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	
ROOT RESECTION/HEMISECTION	150.00	
*** RETREATMENT OF ROOT CANAL THERAPY BY SPECIALIST, ADDITIONAL**	100.00	
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	200.00	
MAXIMUM CHARGE PER CASE	**2520.00**	

	MAXIMUM CHARGES	
V-PERIODONTICS		
GINGIVECTOMY-PER QUADRANT	125.00	
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	
GINGIVAL CURRETAGE-PER VISIT	50.00	
PEDICAL SOFT TISSUE GRAFT-PER QUAD	200.00	
FREE SOFT TISSUE GRAFT-PER QUAD	250.00	
APICAL REPOSITIONING	175.00	
VI-PROSTHODONTICS		
COMPLETE OR IMMEDIATE DENTURE	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	75.00	
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	350.00	*
PONTIC-PORCELAIN TO METAL	425.00	*
PONTIC-RESIN WITH METAL	375.00	*
CAST METL RETNR-ACID ETCH BRIDGE	230.00	
ABUTMENT-PLASTIC WITH METAL	350.00	*
ABUTMENT-3/4 CAST	350.00	*
ABUTMENT-PORCELAIN WITH METAL	425.00	*
ABUTMENT-FULL CAST	350.00	*
RECEMENT BRIDGE OR SPACE MAINTAINER	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- AID ERUPTION	80.00	
FOR ORTHODONTIC PURPOSES	160.00	
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	
GENERAL ANESTHESIA-1ST 30 MINUTES	125.00	

*** INCLUDES $100 MEMBER CO-PAYMENT FOR ACTIVE CIVIL SERVICE MEMBERS ONLY**