GENERAL BUILDING LABORERS' LOCAL UNION NO. 66 WELFARE FUND
METRODENT PREMIER NETWORK
PLAN DESCRIPTION & FEE SCHEDULE

This document is a brief description of the program. Please refer to the Summary Plan Description and other documents for a comprehensive listing of plan provisions, limitations and exclusions.

ELIGIBILITY	• **Eligible dependents** include spouses, dependent children to the end of the calendar year in which they turn 26.
PLAN YEAR	• January 1 st through December 31 st
ANNUAL MAXIMUM	• There is no annual maximum
DEDUCTIBLE	• There is no annual deductible
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – **panoramic or full mouth series –** not more then one in thirty six months • **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, one application per lifetime. • **Fluoride treatment** – to age 19, maximum one application per calendar year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – one curretage per visit. maximum of $200 in a calendar year • **Orthodontic Treatment** – The maximum lifetime benefit payable for orthodontic services is $2020 for each covered individual. When the maximum is reached, the member is responsible to pay the Orthodontist directly according to the scheduled allowance listed in the schedule up to a maximum of $500. • **Specialist consultation –** one in a calendar year • **Implants** - two per jaw per lifetime and two in 12 months
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:** no surcharge permitted • **Covered and reimbursable services, with co-payment:** only established co-payment • **Covered but not reimbursable services:** Scheduled allowance plus 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 and payments from the other plan must first be applied to reduce or eliminate co-payments or charges levied due to maximums.
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. 67 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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Implantology:

	Maximum Charge	Plan Pays	Member Pays
Endosteal Implant	$1,200.00	$600.00	$600.00
Subperiosteal Implant	$1,200.00	$600.00	$600.00
Transosseous Implant	$1,200.00	$600.00	$600.00
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
Bone Graft At The of Implant Placement	$300.00	$150.00	$150.00
Bone Graft-Ridge Preservation	$300.00	$150.00	$150.00
Implant Supported Crown	$1000.00	$500.00	$500.00

* Two per jaw per lifetime with a maximum of two Implants in any 12 month period.

Self-Insured Dental Services / Administrative Services Only, Inc. Dental Plan Administrators

General Building Laborers' Local Union No.66 Welfare Fund
Dental Schedule of Allowances

DIAGNOSTIC	Plan Alowance	Member Copay
ORAL EXAM	17.00	
FULL MOUTH SERIES/PANORAMIC FILM	40.00	
CEPHALOMETRIC FILM	40.00	
INTRAORAL X-RAY (EACH FILM)	5.00	
BITEWING, first film	5.00	
BITEWING, each additional film	5.00	
OCCLUSAL FILM	15.00	
EXTRAORAL, TMJ FILM	25.00	
POSTERIOR-ANTER., LATERAL	25.00	
CEPHALOMETRIC FILM	40.00	
CONE BEAM CT	100.00	100.00
PULP VITLITY TEST	20.00	
PREVENTIVE		
PROPHYLAXIS-ADULT	30.00	
PROPHYLAXIS-CHILD	25.00	
FLUORIDE EXCL. PROPHY	10.00	
SEALANT-PER TOOTH	15.00	
SPACE MAINTAINER	150.00	
RESTORATIVE		
AMALGAM FILLINGS		
one surface	45.00	
two surfaces	55.00	
three surfaces or more	60.00	
COMPOSITE RESIN		
one surface	52.00	
two surfaces	60.00	
three or more surfaces	70.00	
RESIN, INCISAL ANGLE	80.00	
METALLIC OR PORC. INLAY/ONLAY		
one surface	200.00	
two surfaces	230.00	
three surfaces	260.00	
CROWN-PORCELAIN/CERAMIC SUBSTRATE	225.00	
CROWN-PLASTIC WITH METAL	250.00	
CROWN-PORCELAIN JACKET	225.00	
CROWN-PORCELAIN WITH METAL	300.00	
FULL OR 3/4 CAST CROWN	225.00	125.00
ACRYLIC JACKET	125.00	125.00
LABIAL VENEER-lab processed	150.00	125.00
STAINLESS STEEL CROWN-PRIMARY	100.00	125.00
PREFAB POST AND CORE	86.00	125.00
CAST POST & CORE	125.00	125.00
PIN RETENTION-PER TOOTH	20.00	125.00
RECEMENT CROWN OR INLAY	30.00	
RECEMENT POST	40.00	
ENDODONTICS		
PULP CAP	15.00	
VITAL PULPOTOMY	75.00	
ROOT CANAL THERAPY-anterior	225.00	
ROOT CANAL THERAPY-bicuspid	275.00	
ROOT CANAL THERAPY-molar	350.00	
RETREAT ROOT CANAL-anterior	450.00	
RETREAT ROOT CANAL-bicuspid	550.00	
RETREAT ROOT CANAL-molar	700.00	
POST REMOVAL	75.00	75.00
APICOECTOMY-PER ROOT	130.00	
APICO-MAXIMUM PER TOOTH	260.00	
RETROGRADE FILLING	85.00	
ADJUNCTIVE SERVICES		
PALLIATIVE TREATMENT	30.00	
GENERAL ANESTHESIA per 15 min, max 30 min	62.50	
CONSULTATION BY SPECIALIST	50.00	
BRUXISM APPLIANCE	150.00	

PERIODONTICS	Plan Allowace	Member Copay
GINGIVECTOMY	150.00	
GUIDED TISSUE REGENERATION-RESORB	115.00	115.00
GUIDED TISSUE REGENERATION-NONRESORE	140.00	140.00
BIO MATERIAL TO AID REGENERATION	75.00	75.00
FREE SOFT GRAFT-PER QUAD	225.00	
OSSEOUS GRAFT-PER SITE	125.00	
OSSEOUS GRAFT, ADD. Max 2 per quad	125.00	
OSSEOUS SURGERY includ gingivectomy per qu	250.00	125.00
PEDICLE SOFT TISSUE GRAFT	175.00	
OCCLUSAL ADJUSTMENT-COMP	60.00	
PERIO SCALE-PER QUAD	50.00	
PERIO SCALE-1-3 TEETH	30.00	
PERIO MAINTENANCE following periodontal surgery	55.00	
PROSTHODONTICS		
DENTURE-PERMANENT OR IMMEDIATE	475.00	125.00
PARTIAL DENTURE-ACRYLIC BASE	300.00	125.00
PARTIAL DENTURE-CAST BASE	475.00	125.00
UNILATERAL PARTIAL DENTURE	125.00	125.00
REPAIR COMP DENT BASE	90.00	
ADJUST DENTURE	35.00	
REPLC MISS/BRKN TTH-COM DENT	75.00	
REPAIR PART ACRYLIC SADDLE/BASE	80.00	
REPAIR CAST FRAMEWORK	95.00	
REPLACE BROKEN TOOTH	85.00	
REPLACE BROKEN CLASP	85.00	
ADD CLASP TO EXISTING PART DENT	85.00	
REPLACE BROKEN FACING	100.00	
RELINE COMPLETE DENTURE-CHAIR	80.00	
RELINE PARTIAL DENTURE-CHAIR	75.00	
RELINE COMPLETE DENTURE-LAB	125.00	
RELINE PARTIAL DENTURE-LAB	100.00	
PONTIC-FULL CAST	300.00	125.00
PONTIC-PORCELAIN TO METAL	300.00	125.00
PONTIC-RESIN WITH METAL	205.00	125.00
RECEMENT BRIDGE	40.00	
RECEMENT SPACE MAINTAINER	40.00	
ORAL SURGERY		
SIMPLE EXTRACTION	50.00	
SURGICAL EXTRACTION	75.00	
RETAINED ROOT	90.00	
IMPACTION-SOFT TISSUE	115.00	
IMPACTION-PARTIAL BONY	185.00	
IMPACTION-COMPLETE BONY	225.00	
BIOPSY OF ORAL TISSUE	100.00	
ALVEOPLASTY PER JAW	125.00	
CYST REMOVAL < 1.25CM	75.00	
INCISION & DRAINAGE	50.00	
no other treatment that visit		
FRENULECTOMY	95.00	
ROOT RESECTION	150.00	
OSSEOUS GRAFT-MANDIBLE OR MAXILLA	400.00	400.00
SINUS AUGMENTATION WITH BONE	400.00	400.00
PRIMARY CLOSURE OF A SINUS PERFORATIO	225.00	225.00
ORTHODONTICS		
DIAGNOSIS & INITIAL APPLIANCES		
removable appliance	300.00	
fixed appliance	565.00	
ACTIVE TREATMENT, 24 months	60.00	
PASSIVE TREATMENT,per 3 months, max 9 mon	55.00	
POST-TREATMENT STABILIZATION DEVICE	150.00	
HARMFUL HABIT APPLIANCE	270.00	
PRE-ORTHO TREATMENT (records)	150.00	

MAXIMUM CHARGE PER CASE $2,520 incl $500 copay