NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS (NYDCC) WELFARE FUND
NYDCC / 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.

ELIGIBILITY	• Eligibility is determined according to the definition and requirements outlined in the NYDCC Summary Plan Description. **Eligible dependents** include the lawful spouse and unmarried children to the end of the month in which they reach age 26.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• **Active members** - $2500 annual maximum, excluding orthodontic services • **Retired members** - $1500 annual maximum, excluding orthodontic services
ORTHODONTIC MAXIMUM	• 24 months of active treatment and 3 visits in 18 months of passive treatment
DEDUCTIBLE	• $100 annual deductible, per person per calendar year. Waived for diagnostic, preventive and orthodontic services
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two per calendar year • **X-rays** - $50 maximum per calendar year • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored posterior teeth, to age 15, lifetime maximum $45 per quadrant. • **Fluoride treatment** – to age 15, maximum two applications per year • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – per visit, maximum $200 per calendar year • **Periodontal surgery –** charting and x-rays required; 1 in 36 consecutive months • **Orthodontics –** 24 months of active treatment, 18 months passive • **Specialist consultation –** one per year, no other treatment that same visit, includes allowance for examination • **Denture adjustment** – one in six consecutive months • **Rebasing or relining denture** – once in a three year period
PLAN EXCLUSIONS	• When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure
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:** None • **Covered but not reimbursable services:** Schedule allowance • **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 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. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : Self-Insured Dental Services, Dept 95. P.O. Box 9007 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

Rev 1/18

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IMPLANT AND IMPLANT RELATED SERVICES:

	Maximum Charge	Plan Pays	Member Pays
Endosteal Implant	$1,200.00	$1200.00	$0.00
Endosseous Implant	$1,200.00	$1200.00	$0.00
Subperiosteal Implant	$1,200.00	$1200.00	$0.00
Transosseous Implant	$1,200.00	$1200.00	$0.00
Prefabricated Abutment	$475.00	$200.00	$275.00
Custom Abutment	$475.00	$200.00	$275.00
Abutment Supported Porcelain Ceramic Crown	$675.00	$375.00	$300.00
Abutment Supported Porcelain/Metal Crown	$675.00	$375.00	$300.00
Abutment Supported Base Metal Crown	$675.00	$375.00	$300.00
Abutment Supported Crown	$600.00	$375.00	$300.00
Abutment Supported Cast High Noble Metal Crown	$675.00	$375.00	$300.00
Abutment Supported Noble Metal Crown	$600.00	$375.00	$225.00
Implant Supported Porcelain Ceramic Crown	$975.00	$375.00	$600.00
Implant Supported Porcelain/High Noble Metal Crown	$975.00	$375.00	$600.00
Implant Supported High Noble Metal Crown	$975.00	$375.00	$600.00

Radiographs of the entire arch are required for evaluation. There is a five-year frequency limitation for the replacement of prosthetic devices.

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

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS
SCHEDULE OF ALLOWANCES

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	15.00
X-RAYS (FULL MOUTH SERIES)	30.00
PA OR BW EACH FILM	4.00
OCCLUSAL FILM	13.00
POSTERIOR-ANTERIOR OR LATERAL FILM	32.00
PANORAMIC FILM	30.00
CEPHALOMETRIC FILM	34.00
TEMPOROMANDIBULAR FILM	40.00
II-PREVENTIVE	
PROPHYLAXIS-Adult	28.00
PROPHYLAXIS-Child	25.00
FLUORIDE EXCL. PROPHY	18.00
SEALANT-to age 15	15.00
SPACE MAINTAINER-ACRYLIC	98.00
SPACE MAINTAINER-METAL	135.00
III-RESTORATIVE	
AMALGAM - 1 SR-Primary	25.00
AMALGAM - 2 SRF-Primary	35.00
AMALGAM - 3 SRF-Primary	48.00
AMALGAM- 4 + Surfaces Primary	65.00
AMALGAM - 1 SR-Permanent	35.00
AMALGAM - 2 SRF-Permanent	45.00
AMALGAM - 3 SRF-Permanent	55.00
AMALGAM- 4 + Surfaces-Permanent	65.00
RESIN-1 SURFACE-Anterior	35.00
RESIN-2 SURFACE-Anterior	45.00
RESIN-3 OR MORE SURFACES -Anterior	60.00
INCISAL ANGLE	60.00
RESIN-1 SURFACE-Posterior	40.00
RESIN-2 SURFACE-Posterior	50.00
RESIN-3 OR MORE SURFACES-Posterior	60.00
PORCELAIN OR METALLIC INLAY-1 SRF	200.00
PORCELAIN OR METALLIC INLAY-2 SRF	250.00
PORCELAIN OR METALLIC INLAY-3 SRF	300.00
CROWN-PLASTIC	120.00
CROWN-PLASTIC TO METAL	325.00
CROWN-PORCELAIN	325.00
CROWN-PORCELAIN TO METAL	375.00
CROWN-FULL CAST	350.00
CROWN-3/4 CAST	300.00
PORCELAIN LAMINATE	225.00
CAST POST AND CORE	100.00
PREFAB POST AND CORE	86.00
PIN SUPPORT PER TOOTH	15.00
RECEMENT CROWN OR INLAY	25.00
PREFAB SS CROWN-primary teeth only	100.00
IV-ENDODONTICS	
PULP CAP	10.00
VITAL PULPOTOMY	75.00
ROOT CANAL THERAPY-ANTERIOR	200.00
ROOT CANAL THERAPY-BICUSPID	250.00
ROOT CANAL THERAPY-MOLAR	325.00
RETROGRADE FILLING	60.00
APICOECTOMY	130.00
APICOECTOMY-max per tooth	260.00
HEMISECTION/ROOT RESECTION	105.00
V-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT	30.00
SEDATIVE FILLING	30.00
GENERAL ANESTHESIA/IV SEDATION	
Plan pays first 30 minutes only	110.00
BRUXISM APPLIANCE	225.00
SPECIALIST CONSULTATION	50.00
OCCLUSAL ADJUSTMENT	40.00
BLEACHING, PER ARCH-CHAIRSIDE ONLY	150.00
BEHAVIOR MANAGEMENT-**FOR PARTICIPATING PEDODONTISTS ONLY**	50.00

	MAXIMUM CHARGE
VI-PERIODONTICS	
GINGIVECTOMY-PER QUAD	150.00
OSSEOUS SURGERY-PER QUAD	375.00
OSSEOUS GRAFT-Single site	75.00
OSSEOUS GRAFT-Per quadrant	300.00
OSSEOUS GRAFT-Maximum per jaw	500.00
FREE SOFT TISSUE GRAFTS-Per quadrant	200.00
PEDICLE SOFT TISSUE GRAFTS	200.00
LOCALIZED DELIVERY OF CHEMO AGENT	50.00
CURETTAGE, SCALE\ROOT PLANING-two or more quads	75.00
CURETTAGE, SCALE\ROOT PLANING-per quad	50.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00
VII-ORAL SURGERY	
SIMPLE EXTRACTION	40.00
SURGICAL EXTRACTION	65.00
IMPACTION-SOFT TISSUE	100.00
IMPACTION-PARTIAL BONY	175.00
IMPACTION-COMPLETE BONY	200.00
REMOVAL OF RESIDUAL ROOTS	90.00
SURGICAL EXPOSURE-UNERUPTED (for ortho)	175.00
SURGICAL EXPOSURE-UNERUPTED (aid eruption)	125.00
BIOPSY HARD TISSUE	100.00
BIOPSY SOFT TISSUE	84.00
CYST/TUMOR REMOVAL <1.25	75.00
CYST/TUMOR REMOVAL >1.25	100.00
ALVEOPLASTY-PER JAW	125.00
REMOVAL OF CYST OR TUMOR	100.00
FRENULECTOMY	95.00
INCISION AND DRAINAGE-NO OTHER TREATMENT	50.00
VIII-PROSTHODONTICS	
COMPLETE OR IMMEDIATE DENTURE	400.00
PARTIAL DENTURE-ACRYLIC BASE	325.00
PARTIAL DENTURE-CAST BASE	400.00
UNILATERAL PARTIAL DENTURE	
ONE TOOTH	240.00
EACH ADDITIONAL TOOTH	100.00
DENTURE ADJUSTMENT	25.00
REPAIR ACRYLIC SADDLE OR BASE	70.00
ADD, REPAIR OR REPLACE CLASP	75.00
REPAIR CAST FRAMEWORK	90.00
REPLC MISS/BRKN TTH-COM DENT	65.00
RELINE FULL OR PARTIAL DENTURE-CHAIRSIDE	80.00
RELINE FULL DENTURE-LABORATORY	125.00
RELINE PARTIAL DENTURE-CHAIRSIDE	100.00
PONTIC-CAST METAL	300.00
PONTIC-PORCELAIN TO METAL	375.00
PONTIC-RESIN WITH METAL	300.00
ABUTMENT- INLAY 2 SURFACE	250.00
ABUTMENT- INLAY 3 SURFACE	300.00
CAST METL RETNR-ACID ETCH	200.00
ABUTMENT-PLASTIC WITH METAL	325.00
ABUTMENT-PORCELAIN WITH METAL	375.00
ABUTMENT-FULL CAST	350.00
PRECISION ATTACHMENT	100.00
REPLACE FACING	100.00
RECEMENT BRIDGE	30.00
IX-ORTHODONTICS	
INITIAL FIXED APPLIANCE	450.00
ACTIVE TREATMENT-PER MONTH-24 month max	50.00
POST-TREATMENT STABILIZATION-PER RETAINER	110.00
PASSIVE TREATMENT-PER SIX MONTHS	100.00
REMOVABLE APPLIANCE-tooth guidance	225.00
HARMFUL HABIT APPLIANCE	225.00

Rev 1/18