IRONWORKERS LOCAL 40, 361, 417 HEALTH FUND
METRODENT MAX 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** – The lawful spouse and each unmarried child from birth until the last day of the calendar year in which the child reaches age 19 or the end of the calendar year in which the child reaches age 26 when attending and accredited school or college on a fulltime basis. • **To confirm eligibility** please call (212) 684-1586
PLAN YEAR	• January 1 st through December 31 st
PLAN 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 –** one in thirty six months • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, one application in a calendar year • **Sealant –** unrestored permanent posterior teeth, to age 19, one application per lifetime • **Replacement of crowns and bridges –** not more than once in three years • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum of $280 in a calendar year • **Orthodontic treatment –** lifetime maximum for orthodontics is $5,500 per covered individual. Participating Orthodontists must limit their charges to the scheduled allowance. • 24 months active treatment, 9 months passive treatment • **Implants –** The lifetime maximum for Endosteal Implants is four per arch. Participating providers are **not** required to accept the scheduled allowance for Implants as payment in full. • **Specialist consultation –** one per calendar year
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 surcharge permitted, except for implants • **Covered but not reimbursable services:** Schedule allowance, except for implants • **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 : Iron Workers Locals 40, 361 & 417 Health Fund 451 Park Avenue South New York, NY 10016

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

Rev 1/23

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

Iron Workers Local 40, 361 & 417 Health Fund
Schedule of Dental Plan Allowances

DIAGNOSTIC & PREVENTIVE	Plan Pays
ORAL EXAMINATION	35
X-RAYS-FULL MOUTH	90
PERIAPICAL X-RAY FIRST FILM	14
X-RAY PERIAPICAL -ADDITIONAL	8
0CCLUSAL FILM	20
XRAY-EXTRAORAL	40
X-RAY 1 BITEWING	12
X-RAYS 2 BITEWINGS	18
X-RAYS 3 BITEWINGS	24
X-RAYS 4 BITEWINGS	32
VERTICAL BITEWINGS 7-8 FILMS	35
X-RAY ANT. POST. OR LATERAL	30
SIALOGRAPHY	85
TMJ FILM	50
PANORAMIC FILM	55
CEPHALOMETRIC FILM	60
CONE BEAM CT	300
BACTERIOLOGIC STUDIES	40
ADJUNCTIVE PRE-DIAGNOSTIC TEST	50
PULP VITALITY TEST	35
DIAGNOSTIC CASTS	65
PROPHYLAXIS	70
PROPHYLAXIS-CHILD	60
TOPICAL FLUORIDE VARNISH	25
TOPICAL APPLICATION FLUORIDE	25
SEALANT	30
INTERIM CARIES ARRESTING MEDICAMENT APPLICATI(	30
SPACE MAINTAINER	150
RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAIN	40
RESTORATIVE	
AMALGAM ONE SURFACE -PERMANENT OR PRIMARY	105
AMALGAM TWO SURFACES-PERMANENT OR PRIMARY	115
AMALGAM THREE SURFACES-PERM OR PRIME	125
AMALGAM-FOUR OR MORE SURFACES PERM OR PRIM	130
RESIN - ONE SURFACE	115
RESIN - TWO SURFACES	125
RESIN THREE OR MORE SURFACES	135
RESIN-4+ SRF OR INCISAL EDGE	135
RESIN 1 SURFACE POSTERIOR	115
RESIN-2 SURFACES,POSTERIOR	125
RESIN-3 SURFACES,POST.	135
INLAY-METALLIC -ONE SURFACE	270
INLAY METALLIC -TWO SURFACES	300
INLAY-METALLIC-THREE OR MORE S	350
ONLAY-METALLIC 3 SURFACE	444
ONLAY-METALLIC 4+ SURFACE	450
INLAY-PORCELAIN 1 SURFACE	270
INLAY-PORCELAIN 2 SURFACES	300
INLAY-PORCELAIN-3 OR MORE SURF	350
ONLAY-PORCELAIN/CERA,IC 3 SURFACE	600
ONLAY -PORCELAIN/CERAMIC - FOUR OR MORE SURFA	650
INLAY-COMPOSITE-ONE SURFACE	180
INLAY COMPOSITE 2 SRF	275
INLAY COMPOSITE 3 SRF	300
CROWN-RESIN (LABORATORY)	350
CROWN RESIN WITH METAL	515
CROWN - PORCELAIN/CERAMIC SUBSTRATE	650
CROWN-PORC.FUSED TO METAL	700
CROWN-PORC.FUSED TO BASE METAL	650
CROWN-PORC.FUSED TO NOBLE META	675
CROWN-FULL CAST METAL	625
CROWN-FULL CAST BASE METAL	625
CROWN-FULL CAST NOBLE METAL	625
RECEMENT INLAY	50
RECEMENT POST & CORE	50
RECEMENT CROWN	70
PREFABRICATED SS CROWN-PRIMARY	130
PROTECTIVE RESTORATION	50
CROWN BUILD-UP	75
PIN SUPPORT PER TOOTH	35
CAST POST & CORE	215
PREFAB POST & CORE	150
POST REMOVAL	125
LABIAL LAMINATE	300
RESIN LAMINATE-LABORATORY	275
PORCELAIN LAMINATE	500

ENDODONTICS	
PULP CAP-DIRECT	35
PULP CAP-INDIRECT	25
VITAL PULPOTOMY	85
PULPAL THERAPY-PRIMARY-ANTERIO	75
PULPAL THERAPY-PRIMARY-POSTERI	75
ROOT CANAL THERAPY-ANTERIOR TOOTH	560
ROOT CANAL THERAPY-BICUSPID TOOTH	625
ROOT CANAL THERAPY-MOLAR TOOTH	750
TX OF ROOT CANAL OBSTRUCTION	150
RETREATMENT-RCT -ANTERIOR	675
RETREATMENT OF RCT - BICUSPID	725
RETREATMENT RCT-MOLAR	800
APRXIFICATION-INITIAL	325
APICOECTOMY-FIRST ROOT	350
APICO.-PREMOLAR-FIRST ROOT	350
APICO.-MOLAR-FIRST ROOT	350
APICOECTOMY-EACH ADDITIONAL RT	300
RETROGRADE FILLING	185
ROOT RESECTION	225
HEMISECTION	180
PERIODONTICS	
GINGIVECTOMY OR GINGIVOPLASTY	300
GINGIVECTOMY ONE TO THREE TEETH-PER QUAD	72
GINGIVAL FLAP PROCEDURE	350
GINGL FLP PROC 1-3 CONTIG/BOUND TEETH SP	225
APICALLY POSITIONED FLAP	180
CROWN LENGTHENING	575
MUCO-GINGIVAL SURG. PER QUAD.	66
OSSEOUS SURGERY-PER QUADRANT	650
OSSEOUS SURGERY 1 -3 TEETH	390
OSSEOUS GRAFT- PER SITE	210
OSSEOUS GRAFT-ADDTIONAL	120
BIO MATERIALS TO AID REGEN	175
GUIDED TISSUE REGEN-RESORB	275
PEDICLE SOFT TISSUE GRAFTS	275
FREE SOFT TISSUE GRAFTS	385
SUBEPITHELLAL CONNECTIVE TISSUE GRAFT	700
FREE SOFT TISSUE GRAFT	400
PERIO TREATMENT PER QUAD	100
SCALING-ROOT PLANING 1 TO 3 TEETH	80
FULL MOUTH DEBRIDEMENT	80
LOCALIZED DELIV. OF CHEMO.AGEN	60
PERIODONTAL MAINTENANCE	80
ORAL SURGERY	
EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	90
SURGICAL EXTRACTION	180
REMOVAL-SOFT TISSUE IMPACTED	260
REMOVAL-PARTIAL BONY IMPACTED	350
REMOVAL-COMPLETE BONY IMPACTED	470
COMPLETE BONY IMPACT-W/COMP	470
REMOVAL OF RESIDUAL ROOTS	180
TOOTH REIMPLANTATION	75
SURG.EXP-IMP/UNERUP(FOR ORTHO)	400
SURG.EXP-IMP/UNERUP(AID ERUPT)	400
Mobilization of Tooth to Aid Eruption	275
DEVICE TO AID ERUPTION OF IMP	90
BIOPSY HARD TISSUE	200
BIOPSY SOFT TISSUE	200
SURGICAL REPOSITIONING OF TEET	200
ALVEOLECTOMY	150
ALVEOLOPLASTY W/EXT PER QD-1 TO 3 TEETH	90
ALVEOLECTOMY-PER QUAD.-NO EXT	150
CYST/TUMOR REMOVAL < 1.25 CM	150
CYST OR TUMOR REM- > 1.25 CM	150
CYST REMOVAL (NONODONT) <1.25	90
REMOVAL OF NON ODONT >1.25	150
INCISION AND DRAINAGE	120
INCISION & DRAINAGE EXTRAORAL	120
OSSEOUS GRAFT-MANDIBLE OR MAXILLA	1000
SINUS AUGMENTATION WITH BONE	1000
SINUS AUGMENTATION VIA A VERTICAL APPROACH	1000
BONE GRAFT-RIDGE PRESERVATION	350
BUCCAL/LABIAL FRENECTOMY (FRENULECTOMY)	200
LINGUAL FRENECTOMY (FRENULECTOMY)	200
EXCISION-PERICORONAL GINGIVA	75

PROSTHODONTICS	Plan Pays
COMPLETE DENTURE	1000
IMMEDIATE FULL DENTURE	1000
PARTIAL DENTURE-ACRYLIC BASE W/C	750
PARTIAL DENTURE - CAST METAL	1000
REMOVABLE UNILATERAL	300
ADJUST COMPLETE DENTURE	45
ADJUST PARTIAL DENTURE	45
REPAIR BROKEN COMPLETE DENTURE BASE	120
REPLACE BROKEN TTH IN DENTURE	115
REPAIR RESIN PARTIAL DENTURE BASE	120
REPAIR CAST PARTIAL FRAMEWORK	130
REPAIR OR REPLACE BROKEN CLASP	115
REPLACE BROKEN TOOTH	115
ADD TOOTH TO DENTURE	115
ADD CLASP TO EXIST PART DENT	115
REBASE FULL DENTURE	250
REBASE PARTIAL DENTURE	180
RELINE COMPLETE OR PARTIAL (CHAIRSIDE)	180
RELINE COMP DENTURE-LAB	225
RELINE PARTIAL DENTURE -LAB	200
TISSUE CONDITIONING-	50
OVERDENTURE-COMPLETE	480
OVERDENTURE-PARTIAL	400
ENDOSTEAL IMPLANT	1400
IMPLANT CONNECTING BAR	525
PREFABRICATED ABUTMENT	650
CUSTOM ABUTMENT	650
ABUTMENT SUPPORTED	850
IMPLANT SUPPORTED PORC/CER CR	1000
IMPLANT SUP PORC/HIGH NOBEL	1000
IMPLANT SUPP HIGH NOBLE METL	850
ABUT SUPRTD RETNR-PORC FUSD MET FPD	825
ABUT SUPPORTED RETAINER PORCELN FUSED MI	850
IMPL SUPP RETAIN FOR PORC FPD	785
IMPLANT MAINTENANCE PROCEDURES	100
REPAIR IMPLANT, BY REPORT	200
REPLACEMENT OF PRECISION ATTAC	300
RCMNT IMP/ABUT SUPPORTED CRWN	70
RECEMENT IMPLANT/ABUTMENT SUPPORTED FI	70
IMPLANT REMOVAL, BY REPORT	250
DEBRIDEMENT OF A PERI-IMPLANT DEFECT	300
DEBRIDEMENT AND OSSEOUS CONTOURING OF A	350
BONE GRAFT AT TIME OF IMPLANT PLACEMENT	350
PONTIC CAST GOLD	600
PONTIC-FULL CAST NOBLE METAL	425
PONTIC PORC FUSED TO METAL	650
PONTIC RESIN WITH METAL	500
INLAY-METALLIC-2 SURFACES	276
INLAY-METAL-3 SURF.ABUTMENT	312
MARYLAND BRIDGE RETAINER	550
ABUTMENT RESIN WITH METAL	375
ABUTMENT-PORC. FUSED TO METAL	650
ABUTMENT-3/4 CAST OR FULL CAST METAL	425
RECEMENT BRIDGE	75
PRECISION ATTACHMENT	480
ORTHODONTICS	
LIMITED ORTHODONTIC TX	700
INITIAL ORTHO APPLIANCE	1000
REMOVABLE APPLIANCE THERAPY	350
ACTIVE ORTHO TREAT PER MONTH	150
ORTHO RETENTION (REMOV APP, CONSTR/PLACE	300
REMOVABLE ORTHODONTIC RETAINER ADJUSTM	150
ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT	50
DEEP SEDATION/GENERAL ANES-PER 15 MIN	100
INTRAVENOUS MODERATE SEDATION-PER 15 MI	100
MAX 30 MINUTES	
SPECIALIST CONSULTATION	80
OCCLUSAL GUARD HARD OR SOFT APPLIANCE, FU	300
OCCLUSAL ADJUSTMENT-LIMITED	60
OCCLUSAL ADJUSTMENT-COMPLETE	275