ADMINISTRATIVE
Services Only, Inc.

DENTAL BENEFIT PLAN

Administered By

ADMINISTRATIVE SERVICES ONLY, INC
SELF-INSURED DENTAL SERVICES

For Participants Of

New York City District Council of Carpenters
BENEFIT FUNDS

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FOR:
Directory of Participating Dentists | Schedule of Benefits | Claims History | Claim Forms

JANUARY 1, 2018

ATTENTION

This brochure provides a brief general description of the dental benefit program provided by the Fund, written in non-technical language. Nothing in this brochure is meant to interpret or extend or change in any way the provisions of your Plan. All provisions are subject to the terms and conditions contained in the Summary Plan Description and other Plan Documents. The benefits described in this brochure may be modified or terminated at any time by the Fund's Board of Trustees.

ELIGIBILITY: Your eligibility and the eligibility of your dependents is determined by the Fund Office. Please refer to the NYCDCC Welfare Fund Summary Plan Description.

ANNUAL DEDUCTIBLE: The annual deductible will be waived for diagnostic and preventive services and orthodontic treatment.

Active Carpenters: $100
Retired Carpenters: $100
City of New York: $100
Associations: $100

ANNUAL MAXIMUM:
Active participants have a $2,500 annual maximum per covered individual.
Retirees have a $1,500 annual maximum per covered individual.

ORTHODONTIC BENEFIT: There is a maximum of 24 months of active treatment and 18 months passive.Orthodontic benefits are not subject to the annual maximum or deductible.

COVERED EXPENSES: Covered Expenses include charges incurred for dental procedures listed in the **Schedule of Covered Dental Allowances,** when the dental service is performed by or under the direction of a duly licensed dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A dental service is deemed to start when the actual performance of the service starts except that:

- For fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- For a crown, it starts on the first date of preparation of the tooth involved;
- For root canal therapy, it starts when the pulp chamber of the tooth is opened.

HOW TO FILE A CLAIM: After dental work is performed, have your dentist complete all items in the Dentist Information portion of the Claim Form and list the procedures, dates of services and charges and sign in the space provided for dentist signature. You should then complete all items in the Member Information portion. Be sure to include spouse and dependent information.

Completed claim forms, with x-rays and all attachments, should be sent to:

Administrative Services Only, Inc.
Self Insured Dental Services
PO Box 9005, Dept. 95
Lynbrook, NY 11563-9005
516-396-5500 | 800-537-1238

PAYOR ID: CX076

www.asonet.com

Claim Forms are available from:

The Fund Office's website:
www.nyccbf.org

ASO/SIDS website:
www.asonet.com

Dental claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed. **If you would like the payment made directly to your dentist,** you may do so by signing the "Authorization to Assign Benefits" box on the claim form.

PRE-TREATMENT REVIEW: Pre-treatment Review is not mandatory, but highly reccomended. You may take advantage of this process so that you and your dentist can be informed, in advance of treatment and before any expenses are incurred, what benefits are provided by the Dental Program.

A Claim Form for Pre-Treatment Review should be filed by your dentist if the course of treatment prescribed for you is expected to cost more than $500 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, orthodontics, inlays or periodontal surgery. The dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary x-rays and other supporting documentation.

ASO/SIDS will review the proposed treatment and apply the appropriate Plan provisions. You and your dentist will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your dentist.

If you receive a pre-treatment review claim for a proposed course of treatment that was submitted by one dentist, that pre-authorization will remain valid if you elect to have some or all of the work performed by another dentist. The preauthorization will be honored for one year after issuance.

Please be aware that a pre-treatment review claim is not a promise of payment. Work must be completed while you are still eligible for benefits (except where there is an Extension of Benefits) provided that no significant change occurred in the condition of your mouth after the pre-estimate was issued. Payment will be made in accordance with Plan allowances and limitations in effect at the time services are completed.

CLAIMS APPEAL AND REVIEW PROCEDURE: Your right to appeal and review of denied claims is described in the New York City District Council of Carpenters Welfare Fund Summary Plan Description.

EXTENSION OF BENEFITS: An expense incurred in connection with a Dental Service that is completed after a person's eligibility has terminated will be deemed to be incurred while that person was eligible if:

- For crowns, fixed bridgework and full or partial dentures a pretreatment review claim was issued and impressions were taken and/or teeth were prepared while that person was eligible and the device was installed or delivered within three months after that person's eligibility terminated.

- For orthodontic appliances, a pre-treatment review claim was issued and impressions were taken while the individual was eligible and the device was installed within three months after eligibility terminated.

- For root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within three months after that person's eligibility terminated.

There is no extension for any dental service not listed above.

COORDINATION OF DENTAL BENEFITS: If you or your family members are eligible to receive dental benefits under another group plan in addition to the NYCDCC Welfare Fund Dental Plan, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses will be paid jointly by the plans. The allowable expense for a procedure is defined as the average usual and customary charge for a specific geographic area. Members should file with the primary plan first and then the secondary plan. The plan that covers an individual as an employee, or union member pays first, and the plan that covers an individual as a family member pays second. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

BIRTHDAY RULE: The Birthday Rule is applied when determining the primary carrier for payment of dental benefits for dependent children. The plan of the parent whose birthday falls first in the calendar year, by month and day only, is the primary carrier. For example, if your birthday is May 9 and your spouse's birthday is July 27, your dental plan will be primary.

ALTERNATE BENEFIT PROVISION: Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. When the pre-treatment review or claim analysis is performed and there is another treatment plan that could address the problem, A.S.O./S.I.D.S will advise you of the alternative benefit determination. **In these rare instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on the Alternate Course of Treatment.** This should in no way be considered a reflection on your treating dentist's recommendations. By using the pretreatment review and authorization procedures you and your dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a pre-treatment review claim estimate, the benefits paid by the Dental Plan may be based on the alternative treatment.

GUARDED PROGNOSIS LIMITATION: If, in the opinion of the claims administrator, the longevity of the proposed or rendered treatment is limited, payment may be made in accordance with Plan provisions. However, future benefits for additional services may be affected.

COSMETIC LIMITATION: Where there is more then one method of restoring a decayed or fractured tooth, one of which may result in a more esthetic restoration than others, payment will be based on the least costly professionally acceptable treatment option.

EXPENSES NOT COVERED: Covered Expenses will not include, and no payment will be made for, expenses incurred for:

1. Treatment for the purpose of cosmetic improvement.
2. Replacement of a lost or stolen appliance.
3. Replacement of a bridge, crown, inlay or denture within five years after the date it was originally installed.
4. Replacement of a bridge, crown, inlay or denture which is or can be made usable according to common dental standards.
5. Procedures, appliances or restorations (except full dentures) whose main purpose is to:
   a) change vertical dimension; or
   b) diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
   c) stabilize periodontally involved teeth.
6. Multiple bridge abutments.
7. Dental services that do not meet common dental standards.
8. Services not listed in the Schedule of Covered Dental Allowances.
9. Services for which benefits are not payable according to the "General Limitations" section.

GENERAL LIMITATIONS: No payment will be made for expenses incurred for you or any one of your dependents:

1. For or in connection with services or supplies resulting from an accidental injury and which are deemed to be the respon sibility of a third party.
2. For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
3. For or in connection with a sickness which is covered under any workers compensation or similar law.
4. For charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance.
5. To the extent that payment is unlawful where the person resides when the expenses are incurred.
6. For charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family.
7. To the extent that they are more than reasonable and customary charges.
8. For charges for unnecessary care, treatment or surgery.
9. To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program.
10. For or in connection with experimental procedures or treatment methods not accepted.

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND METRODENT DENTAL PPO PROGRAM

This feature of your dental program is designed to provide you with comprehensive dental services while reducing or eliminating your out-of-pocket expenses.

When you use a NYCDCC WF/METRODENT participating dentist you will be provided with the services covered by your Dental Plan without any out-of-pocket expense except as noted below. Since usual and customary charges generally exceed the Allowances listed in the Schedule, this represents an overall savings to you in the cost of your dental services.

When you use a participating provider you will not incur any out-of-pocket expenses except in the following instances:

1. To satisfy the annual deductible. If all or part of the deductible has already been met, your dentist will refund that portion to you when the claim is settled.
2. For services that are listed in the Schedule but for which the Plan will not pay, e.g.:
   a) where the Alternate Benefit Provision is applied
   b) where frequency limitations and/or plan maximums have been met.

   In these instances, the participating dentist's charges may not exceed the Allowances listed in the Schedule.
3. For services where ACO payment is indicated.
4. For non-covered services (there are some procedures not covered by the Plan), you are not to pay more than the dentist's usual and customary charge for that service.

If you are covered under more than one dental plan, the dentist is entitled to the benefits available from both plans. The combined payment for any procedure, however, may not exceed the usual and customary fee for that procedure and payment from the second plan must be applied first toward any applicable deductibles.

SELECTING A DENTIST: It is important to understand that the NYCDCC Welfare Fund does not recommend any particular dentist. You are responsible to select the dentist of your choice, and you should exercise the same care and apply the same criteria in selecting a participating dentist that you would in selecting a non-participating dentist. If you use a participating dentist, you are required to assign benefits on the claim form so that the participating dentist receives payment directly from the Administrator. If you use a non-participating dentist, the Fund will pay up to the allowance listed in the schedule and you will be responsible for the difference between that allowance and your dentist's charge.

SCHEDULING AN APPOINTMENT: To take advantage of this program, select a dentist from the List of Participating dentists and call for an appointment. Be sure to identify yourself as an eligible member of the New York City District Council of Carpenters Welfare Fund. Please note that identification cards are not required or issued for the dental benefits program. The panel of participating dentists was developed in cooperation with our dental consultants, ASO/SIDS. Should you need any assistance with the program, have any specific complaints, suggestions or comments, or if you need an updated List of Participating Dentists please contact:

Administrative Services Only, Inc.
Self Insured Dental Services PO Box 9005, Dept. 95
Lynbrook, NY 11563-9005
516-396-5500 | 800-537-1238

www.asonet.com

It is recommended that you use a participating dentist whenever possible. If you have any problems or complaints or require an explanation of charges please contact Self-Insured Dental Services or the Fund Office.

IMPORTANT

If a service is covered under the Plan and a participating dentist is charging you in addition to the scheduled allowance, you should call ASO/SIDS or the Fund Office before paying the doctor any money and proceeding with the treatment. ASO/SIDS will contact the dental office to discuss the treatment plan, the dentists charges, and the Plan's covered expenses to insure that you will not be erroneously charged for a procedure that the Plan allowance should cover in full.

ADMINISTRATIVE Services Only, Inc.

SCHEDULE OF COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE

	Plan Allowance
ORAL EXAMINATION	15.00
Maximum-two per calendar year	
FULL MOUTH SERIES X-RAYS	
10 to 14 periapical /bitewing films	30.00
PANORAMIC FILM	30.00
PERIAPICAL OR BITEWING, per film	4.00
OCCLUSAL FILM	13.00
CEPHALOMETRICFILM	34.00
POSTERIOR-ANTERIORFILM	29.00
LATERAL FILM	32.00
TEMPOROMANDIBULAR FILM	40.00
X-ray maximum-$50 per calendar year	
PROPHYLAXIS, including scaling and polishing	
Adult	28.00
Child, to age 15	25.00
Maximum-two per calendar year	
FLUORIDETREATMENT	
Excluding prophylaxis	18.00
To age 15, two per calendar year	
SEALANT	15.00
Unrestored permanent posterior teeth only, to age 15	
Lifetime maximum-$45 per quadrant	
SPACE MAINTAINER	
Acrylic	98.00
Metal	135.00

BASIC RESTORATIVE

SILVER AMALGAM FILLINGS	
One surface	35.00
Two surfaces	45.00
Three or more surfaces	55.00
Four or more surfaces	65.00
COMPOSITERESIN-ANTERIOR	
one surface	35.00
two surface	45.00
three surfaces	60.00
four or more and incisal angle	60.00
COMPOSITERESIN-POSTERIOR	
one surface	40.00
two surfaces	50.00
three surfaces	60.00

ENDODONTICS

X-ray evidence of satisfactory completion required

PULPOTOMY	75.00
ROOT THERAPY	
Anterior	200.00
Biscuspid	250.00
Molar	325.00
APICOECTOMY	130.00
APICOECTOMY-max per tooth	260.00
RETROGRADE FILLING	60.00
HEMISECTION / ROOT RESECTION	105.00

MAJOR RESTORATIVE

Pre-operative periapical x-ray required. There is a 5 year frequency limitation on replacements.

	Plan Allowance
CROWNS	
Plastic	120.00
Porcelain jacket	325.00
Plastic with metal	325.00
Porcelain with metal	375.00
Full cast	350.00
3/4 cast	300.00
METALLIC INLAY	
One surface	200.00
Two surfaces	250.00
Three surfaces	300.00
PORCELAIN INLAY	
One surface	200.00
Two surfaces	250.00
Three surfaces	300.00
STAINLESS STEEL CROWN, primary tooth	100.00
CAST POST & CORE	100.00
PREFAB POST AND CORE	86.00

PROSTHODONTICS

Pre-operative x-rays are required when filing a claim for pretreatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five year frequency limitation from date of installation on all prosthetics.

COMPLETE DENTURE	
Immediate or permanent	400.00
PARTIAL DENTURE-unilateral	240.00
PARTIAL DENTURE-bilateral	
Acrylic base with clasps and rests	325.00
Cast metal base	400.00
PRECISIONATTACHMENT	100.00
BRIDGEPONTIC	
Full cast	300.00
Plastic with metal	300.00
Porcelain with metal	375.00
ABUTMENT-INLAY 2 SURFACE	250.00
ABUTMENT-INLAY 3 SURFACE	300.00
CAST METL RETNR-ACID ETCH BRIDGE	200.00
BRIDGE ABUTMENT	
Crown-plastic with metal	325.00
Crown-porcelain fused to metal	375.00
Crown-full cast	300.00
DENTURE RELINE-chair	80.00
DENTURE RELINE-laboratory	125.00
DENTURE REPAIRS	
Denture adjustment	25.00
Repair cast framework	95.00
Repair complete denture base	70.00
Replace tooth in denture	65.00
Replace broken facing	100.00
Add tooth to existing partial denture.	65.00
RECEMENT CROWN OR INLAY	25.00
RECEMENTBRIDGE	30.00

IMPLANTS

	Plan Allowance	Member Co-payments
Endosteal Implant	1,200.00	0
Subperiosteal Implant	1,200.00	0
Transosseous Implant	1,200.00	0
Prefabricated Abutment	200.00	275.00
Custom Abutment	200.00	275.00
Abutment Supported Porcelain Ceramic Crown	375.00	300.00
Abutment Supported Porcelain/Metal Crown	375.00	300.00
Abutment Supported Crown	375.00	225.00
Abutment Supported Cast High Noble Metal Crown	375.00	300.00
Abutment Supported Noble Metal Crown	375.00	225.00
Implant Supported Porcelain Ceramic Crown	375.00	600.00
Implant Supported Porcelain/High Noble Metal Crown	375.00	600.00
Implant Supported High Noble Metal Crown	375.00	600.00

ORTHODONTICS

	Plan Allowance
INITIAL FIXED APPLIANCES	450.00
Maximum one per lifetime	
ACTIVE TREATMENT-per month	50.00
Maximum of 24 mths per lifetime	
POST-TREATMENT STABILIZATION DEVICE	110.00
Maximum one per arch per lifetime	
PASSIVE TREATMENT-per 6 mth	100.00
Maximum of 18 mths per lifetime	
MINOR TOOTH MOVEMENT	
Removable appliance-tooth guidance	225.00
Maximum one per lifetime	
Harmful habit appliance	225.00
Maximum one per lifetime	

ADJUNCTIVE SERVICES

PALLIATIVE TREATMENT-no other treatment that visit	30.00
SEDATIVE FILLING-no other treatment that visit	30.00
GENERAL ANESTHESIA/IV SEDATION	
Per 15 minutes	55.00
Maximum 30 minutes	
BRUXISMAPPLIANCE	225.00
SPECIALIST CONSULTATION-includes examination	50.00
OCCLUSAL ADJUSTMENT	40.00
BEHAVIOR MANAGEMENT-	
Only when rendered by a Participating pedodontist	50.00
In conjunction with other treatment only	
TOOTH WHITENING, per arch	150.00

Must be provided in the dental office in a one-visit chairside setting on natural unrestored teeth. All other tooth whitening products, including all take-home tooth whitening and bleaching products and after-whitening products, are not covered. Lifetime maximum-one treatment per arch.

PERIODONTICS

Although eight teeth constitute the anatomic complement of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant.Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. 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.

	Plan Allowance
ROOT SCALING, GINGIVAL CURETTAGE & BITE CORRECTION, including prophylaxis,	
per quadrant	50.00
two or more quadrants per visit	75.00
periodontal maintenance	60.00
maximum allowance on any combination of the above services is $200 in a calendar year	
PERIODONTAL SURGERY	
confirmation by charting and/or x-rays required per quadrant of at least 5 teeth	
localized delivery of chemotherapeutic agent	50.00
maximum allowance $150 per quadrant	
Gingivectomy, gingivoplasty and mucogingival surgery	
Per quadrant	150.00
Osseous surgery, including gingivectomy-per quad	375.00
Osseous graft, single site	75.00
Osseous graft, per quadrant	300.00
Free soft tissue graft, per quadrant	200.00
Pedicle soft tissue graft, per quadrant	200.00

ORAL SURGERY

ROUTINE EXTRACTION	40.00
SURGICAL EXTRACTION	
Must be demonstrated by pre-operative x-ray	
Erupted tooth	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
INCISION AND DRAINAGE, no other treatment that visit	50.00
ALVEOLOPLASTY-per jaw	125.00
BIOPSY OF ORAL TISSUE-hard tissue	100.00
BIOPSY OF ORAL TISSUE-soft tissue	84.00
REMOVAL OF CYST OR TUMOR - <1.25	75.00
REMOVAL OF CYST OR TUMOR->1.25	100.00
FRENULECTOMY	95.00