Westchester Putnam Counties Heavy & Highway Laborers Local 60

HEALTH AND WELFARE PLAN

DENTAL BENEFITS

You and/or your eligible dependents are covered by the Local 60 Dental Benefit Plan for most standard dental services. This benefit consists of a scheduled dollar benefit allowance for each covered service. This schedule is available in this booklet under "SCHEDULE OF PROCEDURES" and on line at www.local60funds.com or from the Fund Office.

There is a maximum annual benefit of $1,800 per person each calendar year for all covered dental services. There is a separate $1,500 lifetime maximum benefit for covered dependent children under age 19 for pre-certified orthodontic services.

There is a $50.00 annual deductible on Dental services. This deductible does not apply to covered preventative periodic dental services, including prophylaxis, routine examination, corresponding x-rays, and approved orthodontic services.

Choice of Dentist

You may choose any duly licensed dentist or dental surgeon. If you choose to use the services of your own dentist and he or she charges more than the amount allowed in the Plan's dental fee schedule, you will be responsible for paying the difference between the amount billed and the benefit payable by this Dental Plan.

Participating Panel

The Fund Office has put together a list of participating dentists. These professionals have agreed to accept our dental fee schedule as payment in full or will bill you for additional charges at a greatly reduced rate. A list of these participating dentists and any additional charges, if applicable, can be obtained at www.local60funds.com.

Only those dentists whose names appear on the list participate. If their name is not on the list, they do not participate with this Plan. When making an appointment, confirm that the dentist participates with the Local 60 Dental Plan and accepts the Plan's payment as payment in full, except when an additional out of pocket cost for a procedure is specified. If there is any problem, contact the Fund Office BEFORE you commit to an appointment.

The Fund disclaims responsibility for the quality of dental services rendered by any dentist that you may select, including those participating dentists who accept the schedule of benefits.

Precertification Review Process

The precertification review is designed to give you and your dentist a better understanding of the covered expenses payable under this Plan BEFORE treatment begins.

When proposed treatment charges are expected to be more than $300 or if the treatment is for major restorative, periodontal, surgical or orthodontic services, your dentist must submit a precertification form itemizing the proposed services and corresponding fees. A precertification should be submitted to the Fund Office **before** any work is completed. Your dentist will receive the precertification form back with the benefit allowance or denial for each submitted service. If the services are approved and you decide to have the services completed, the dentist will fill in the dates of service on the precertification form once approved services are completed and resubmit the claim to the Fund Office for payment. All pre-certified treatments must be performed within one year of the approved date for payment on those services.

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If you do not follow the precertification review process, the Fund will pay or deny benefits, after taking into consideration alternative procedures or services, based upon acceptable standards of dental practice.

Limitations

- Oral Examination: You and your eligible dependents are allowed one periodic oral examination every six months.
- Intra-Oral x-rays: You and your eligible dependents are allowed a panoramic radiograph (panorex) or a full mouth series (fourteen - eighteen x-rays, including bitewings), once every 36 months.
- Bitewing x-Rays: You and your eligible dependents are allowed up to four once every six months.
- Single x-rays: Up to four single x-rays are allowed annually, if there is a medical necessity or dental emergency.
- Prophylaxis: You and your eligible dependents are allowed one prophylaxis every six months.
- Anesthesia: You and your eligible dependents are covered for general anesthesia only when applicable and pre-certified in conjunction with oral surgery procedures.

Exclusions

- Services performed for cosmetic reasons.
- There is a maximum of three tooth surfaces payable on any one tooth for a filling.
- Replacement of lost or stolen appliances.
- Replacement of a bridge or denture within five years of its installation unless the replacement is necessary because of the placement of an original opposing denture or the extraction of natural teeth. Note: replacement must be medically necessary, as determined by the Plan's Dental Consultant.
- Appliances or restorations, (other than full dentures) whose primary purpose is to alter vertical dimension, stabilize periodontically involved teeth or restore occlusion.
- Dental bonding, adhesives, porcelain veneers or Maryland Bridges.
- Replacement of crowns within five years of their installation. Note: replacement must be medically necessary, as determined by the Plan's Dental Consultant.

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- Replacement of fillings within three years. Note: replacement must be medically necessary, as determined by the Plan's Dental Consultant.
- Relines or rebases of dentures less than one year after insertion.
- Dental mouth guards and similar mouth devices.
- Coverage is not provided for injuries sustained while committing a felony or illegal act.
- Experimental procedures or procedures not approved for a specified service by the American Dental Association.
- Specialized techniques including, but not limited to, precision attachments, implantology and procedures associated therewith, personalization or characterization.
- Orthodontic services commenced on or after a covered individual's 19th birthday.
- Services for Temporomandibular Joint Syndrome or Myofacial Pain Syndrome.
- Sealants, except for untreated permanent molars, once every three years, for children under 16 years of age.
- Fluoride treatment for covered persons age 19 years or older.
- Pulpotomy, except for deciduous (baby) teeth.
- Charges for x-rays taken in conjunction with a root canal treatment and oral surgery services.
- Charges for temporary crowns, bridges or dental flipper.
- Procedures that are not listed on the Plan's fee schedule.

In addition, you are not covered for charges you are not legally required to pay or for charges that would not have been made, had you not had this coverage.

Dental services due to a Workers' Compensation accident/injury are not eligible for payment under this Plan. Benefits will not be paid from the Dental Benefit if they are provided by Federal, State or other laws, unless otherwise required by law.

See the General Exclusions/Limitations section for additional exclusions/limitations.

Extension of Certain Dental Benefits

This Dental benefit provides coverage for crown, bridge, dentures and root canal procedures performed within three months after your eligibility is lapsed, provided the treatment is started before the eligibility is terminated.

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Procedures Applicable to Dental Benefit Claims

A fully itemized claim must be submitted, on a standard dental claim form, in order for it to be considered a completed dental claim under this Plan. The form should contain: the participant's name, patient's name, signature of participant/dependent, patient's date of birth, participant's ID number, date of service, Federal Taxpayer Identification (TIN) and National Provider Identifier (NPI) number of the provider, provider's billing name and address, provider's billed charges, with corresponding treatment rendered stating: the tooth number(s) and/or quadrant(s), identification of tooth surfaces to be restored, and CDT-4 Coding (A.D.A. Procedure codes) for each service rendered. Also, a current coordination of benefits form must be on file at the Fund Office.

If the participant is to be reimbursed due to services rendered outside the participating panel, the participant will need to include the claim form above, but also proof of payment for rendered services.

All claims should be submitted to the Fund Office at:

Attention: Dental Administration
Westchester Putnam Counties Heavy & Highway Laborers
Local 60 Health and Welfare Fund
140 Broadway
Hawthorne, NY 10523
914-769-2440

Other Important Information about your Dental Plan

Please read the following general sections of this Health and Welfare SPD section for important information that also applies to your Dental Plan:

- Member and Dependent Eligibility for Coverage,
- Basic Rules and Exclusions of the Plan,
- Coordination of Benefits (COB),
- Claim Filing and Appeal Procedures,
- Continuation of Coverage (COBRA)

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SCHEDULE OF PROCEDURES

	PLAN ALLOWANCE	
Preventative (1X/6monts)		
Periodic oral examination	$30.00	
Adult prophylaxis	48.00	
Child prophylaxis	32.00	
Sealant	35.00	
Fluoride	28.00	
Radiology		
Single film or single Bitewing	8.00	
Complete FM series (incl bitewings)	60.00	1X/3years
Introral Occlusal film	20.00	
Extraoral film	20.00	
(2) Bitewing x-rays	15.00	
(4) Bitewing x-rays	30.00	
Facial bone survey film	40.00	
Panoramic film	60.00	1X/3 years
Cephalometric film	60.00	
Restoration (fillings) 1X/3yearspertooth		
Amalgam (1) surface	40.00	
Amalgam (2) surfaces	65.00	
Amalgam (3) or more surfaces	75.00	
Resin Composite, (1) surface	45.00	
Resin Composite, (2) surfaces	65.00	
Resin Composite, (3) or more surfaces	80.00	
*** Crowns** 1X/5yearspertooth		
Inlay/onlay	65.00	
3/4 cast gold crown	500.00	
Porcelain crown	500.00	
Resin crown	500.00	
Pin retention	15.00	
Core build-up-incl pins	92.00	
Post & Core	92.00	

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	PLAN ALLOWANCE	
*** Crowns (continued)**		
Resin crown, lab processed (deciduous teeth only)	75.00	
recement post	30.00	
recement crown	30.00	
Stainless steel crown (deciduous teeth only)	40.00	
Replace facing/bridge repair	45.00	
Recement bridge (each abutment)	30.00	
*** Endodontics**		
Anterior root canal (1) canal	275.00	
Bicuspid root canal (2) canals	320.00	
Molar root canal (3) or more canals	400.00	
Apicoectomy	175.00	
Retrograde filling, per root	30.00	
Pulp vitality test	18.00	
Pulpotomy (deciduous teeth only)	45.00	
Hemisection incl root removal	100.00	
*** Periodontics**		
Periodontal scaling, per quadrant (all 4 can be done same day)	65.00	1X/year
Gingivectomy/Gingioplasty, per quad	100.00	
Gingivectomy/Gingioplasty, 1-3 teeth	60.00	
Osseous surg, per quad	330.00	
Osseous surg, 1-3 teeth	110.00	
Bone replacement graft	148.00	
Pedicle soft tissue graft	120.00	
F/M debridment	260.00	
Periodontal maintenance	110.00	1X/year
*** Dentures** 1X/5years		
Complete, upper or lower denture	525.00	
Immediate, upper or lower denture	585.00	
Partial upper or lower	525.00	
Removable unilateral partial denture	225.00	

SCHEDULE OF PROCEDURES

	PLAN ALLOWANCE
*** Dentures (continued)**	
Replace tooth on denture	35.00
Repair denture	30.00
Add/repair/replace clasp to partial denture	45.00
Add tooth to partial denture	40.00
Rebase/reline denture - chairside	65.00
Reline denture - Lab	105.00
****Oral Surgery**	
Simple Extraction	65.00
Surgical removal	95.00
Soft tissue impaction	160.00
Partial bony impaction	190.00
Complete bony impaction	220.00
Surgical access of unerupted tooth	150.00
Extract residual tooth roots	100.00
Biopsy oral tissue	125.00
Alveoplasty, per quadrant	85.00
Vestibuloplasty	175.00
Removal benign odontogenic cyst/tumor	165.00
Remov benign non-odontogenic cyst/tumor	135.00
Removal exostosis	190.00
I & D abscess inter-oral	130.00
I & D abscess extra-oral	220.00
Repair tissue defect	115.00
Lingual frenulectomy	160.00
General anesthesia In-office (first 30 min)	45.00
General anes. In-office (each add'l 15 min)	40.00

***** NOTE: Oral surgery allowance includes x-ray films & all pre & post-operative care***

	PLAN ALLOWANCE
Miscellaneous Procedures:	
Palliative visit (max of 2 visits/year)	30.00
Specialist consultation (in office)	35.00
* Occlusal adjustment	25.00
* Removable appliance	240.00
* Fixed appliance	280.00
* Fixed space maintainer	165.00
* Removable space maintainer	180.00

*** SERVICES REQUIRE PRE-AUTHORIZATION**

PLAN MAXIMUMS

Plan Lifetime Maximums: **$1,500.00**
Orthodontic Benefits for dependent children under age 19.

Plan Annual maximum: **$1,800.00**
Per covered person, per calendar year.

Plan Annual Deductible: **$ 50.00**
Not applicable to orthodontic, periodic preventative oral examination, prophylaxis and corresponding x-rays.