Benefit Booklet

CWA LOCAL 1180 BENEFIT FUNDS

SCHEDULED DENTAL BENEFIT PLAN

- *Comprehensive Benefits for eligible members, spouses and dependent children*
- *Maximum $2,000 per calendar year per person*
- *Separate Orthodontia Maximum for Adults and Children*
- *$2,000 Implant Benefit*
- *Pre-authorization required when charges for a course of treatment include crown and bridgework or will amount to $500 or more*
- *Freedom of Choice in Network or Out of Network*

Dental Claim Office

253 West 35th Street, 12th Floor ■New York, New York 10001-1907
Telephone: (212) 505-5050 ■ Fax: (212) 714-1455 ■ www.dhcook.com

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Damien Arnold
Fund Administrator

The Scheduled Dental Benefit Plan Booklet

January, 2019

Dear Member/Retiree:

We are pleased to provide you with this updated Scheduled Dental Plan Booklet that describes in brief the benefits provided to you through the CWA Local 1180 Benefit Funds' Scheduled Dental Benefit Plan.

To the extent that this booklet describes in brief the Scheduled Dental Benefit Plan, the CWA Local 1180 Security Benefits and Retiree Benefits Funds' Handbooks specify the exact benefits provided and the language within the handbooks will govern in the event of any inconsistency between it and the language of this booklet.

Please refer to the CWA Local 1180 Benefits Handbooks for more detailed information concerning this dental plan. If you have any questions about your benefits, the Fund Office will be pleased to answer them.

Sincerely,

Damien Arnold
Fund Administrator

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THE SCHEDULED DENTAL BENEFIT PLAN BOOKLET

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Scheduled Dental Benefit Plan

What is the Scheduled Dental Benefit Plan?

Under this plan, which is self-insured by the Fund, each covered member and eligible dependent is entitled to a maximum of $2000 for covered services in any calendar year. All covered services are included in the Schedule of Dental Allowances.

How are Benefits Determined?

Benefits paid under the Scheduled Dental Benefit Plan are based on a Schedule of Dental Allowances. If your (non-participating) dentist charges more than the scheduled allowance, you will have to pay the difference. If your dentist charges less than the schedule, you will be reimbursed your dentist's actual fee. Participating dentists will charge only the schedule allowance and accept the Fund reimbursement as payment in-full for covered services.

Claims are not payable to members or their assignees until considered and approved by the Dental Consultant. Such consideration shall not exceed six months from the date the claim is received by the Dental Claim Office.

These benefits will be paid for out-of-hospital care by a provider who is not part of a hospital or outpatient facility. In New York State, under the provisions of the Health Care Reform Act of 1997, if a dentist or covered provider's practice is part of a certain hospital or outpatient facility, benefits will not be paid for their services.

Who are the Participating Dentists?

The Fund has created a panel of dentists who have agreed to provide covered dental procedures at ***no out-of-pocket expense*** *to eligible members, spouses and dependent children who participate in the self-insured dental plan. The listing is provided as a convenient information service. The Fund does not recommend the services of any particular dentist. Participating dentists are selected because they agree to accept the Fund's Schedule of Dental Allowances as* ***payment in-full for covered services****. Please see the Fund's List of Participating Dentists for more information.*

Are the Orthodontic and Implant Benefits Included in the Yearly Maximum?

No. These benefits have separate lifetime maximums. See the Schedule of Dental Allowances for details.

When is Pre-Treatment Review Required?

When the dentist's proposed charges for a course of treatment include crown and bridgework or will amount to $500 or more, dental services must be reviewed by the Dental Claim Office before treatment is rendered.

How Do You File A Claim?

To receive or assign benefits under the Scheduled Dental Benefit Plan, follow these simple steps:

1. *Obtain a claim form from the Fund Office.*
2. *Complete the member's part and sign form <u>after</u> services are rendered.*
3. *When treatment is completed have your dentist complete the Attending Dentist's Statement.*
4. *Within 90 days, submit form to:*

Dental Claim Office
253 W. 35th Street, 12th Floor
New York, NY 10001-1907

Dependents Under Age 19 – No Cost Benefit

Dependents under age 19 must choose a Fund Scheduled Participating Dentist. The plan will have no annual dollar cap for medically necessary orthodontia obtained through a Fund Scheduled Participating Dentist. However, the lifetime limits will remain in place for orthodontia that is not medically necessary – that is, other than in cases of a cleft palate or other deformities that are part of or the result of a congenital defect or anomaly of the mouth that prevents the usual and normal action of mastication and ingestion of normally solid foods. Otherwise, lifetime frequency limitations in the dental schedules do not apply to those under 19.

Intentionally Blank

Schedule of Dental Allowances

Diagnostic

0120	Periodic Oral Evaluation (once in 5 months after initial)	20.00
0140	Limited Oral Evaluation	20.00
0150	Comprehensive Oral Evaluation	20.00
0210	Intraoral - complete series incl. bitewings (once every 3 years)	30.00
0220	Intraoral, Periapical, first film	3.50
0230	Intraoral, Periapical, each additional film	2.00
0270	Bitewings, single film	3.50
0272	Bitewings, two films	7.00
0274	Bitewings, four films	12.00
0290	Posterior-Anterior/lateral skull & facial bone survey film	27.50
0321	Other temporomandibular joint films, by report	36.50
0330	Panoramic film	30.00
0340	Cephalometric film	15.00

Preventive (once every six months)

1110	Prophylaxis - Adult	25.00
1120	Prophylaxis - Child (to age 12)	20.00
1203	Topical application of fluoride prophy not included child	15.00
1204	Topical application of fluoride prophy not included adult	15.00
1351	Sealant - per tooth	25.00
1510	Space Maintainer - Fixed - Unilateral	54.50
1520	Space Maintainer - Removable - Unilateral	54.50

Restorative

2140	Amalgam - 1 Surface, Permanent	25.00
2150	Amalgam - 2 Surfaces, Permanent	35.00
2160	Amalgam - 3 Surfaces, Permanent	45.00
2161	Amalgam - 4 or More Surfaces, Permanent	55.00
2330	Resin, 1 Surface, Anterior	35.00
2331	Resin, 2 Surfaces, Anterior	45.00
2332	Resin, 3 Surfaces, Anterior	60.00
2391	Resin-based composite 1 surface posterior permanent	35.00
2392	Resin-based composite 2 surfaces posterior permanent	45.00
2393	Resin-based composite 3 surfaces posterior permanent	60.00
2394	Resin -based composite 4+ surfaces posterior permanent	60.00
2510	Inlay - Metallic - 1 Surface*	100.00
2520	Inlay - Metallic - 2 Surfaces*	200.00
2530	Inlay - Metallic - 3 Surfaces*	250.00
2610	Inlay - Porcelain/Ceramic - 1 Surface*	80.50
2710	Crown – Resin based composite (indirect)*	150.00
2720	Crown - Resin with high noble metal*	175.00
2721	Crown - Resin with predominantly base metal*	175.00

2722	Crown - Resin with noble Metal*	175.00
2740	Crown - Porcelain/Ceramic Substrate*	175.00
2750	Crown - Porcelain fused to high noble metal*	275.00
2751	Crown - Porcelain fused to predominantly base metal*	275.00
2752	Crown - Porcelain fused to noble metal*	275.00
2790	Crown - Full Cast high noble metal*	250.00
2791	Crown - Full Cast predominantly base metal*	250.00
2792	Crown - Full Cast noble metal*	250.00
2910	Recement inlay, onlay or partial coverage restoration	15.00
2920	Recement crown	20.00
2930	Prefabricated stainless steel crown -primary tooth	47.50
2940	Sedative filling	25.00
2950	Core build-up	85.00
2970	Temporary Crown	36.50
2952	Cast post and core in addition to crown	85.00
2954	Prefabricated post and core in addition to crown	85.00
2980	Crown repair, by report	30.00

** Prosthetics can only be replaced once every five years.*

Endodontics (including x-rays but exclusive of restoration)

3110	Pulp cap - direct (excluding final restoration)	15.00
3120	Pulp cap - indirect (excluding final restoration)	15.00
3220	Therapeutic pulpotomy (exclud. final restoration)	25.00
3310	Anterior Root Canal (exclud. final restoration)	150.00
3320	Bicuspid Root Canal (exclud. final restoration)	200.00
3330	Molar Root Canal (exclud. final restoration)	275.00
3346	Retreatment of previous RCT - anterior	100.00
3347	Retreatment of previous RCT - bicuspid	150.00
3348	Retreatment of previous RCT - molar	200.00
3410	Apicoectomy/Periradicular surgery - anterior	150.00
3421	Apicoectomy/Periradicular surgery - bicuspid (first root)	200.00
3425	Apicoectomy/Periradicular surgery - molar (first root)	250.00
3426	Apicoectomy/Periradicular surgery (each additional root)	125.00
3430	Retrograde filling	60.00

Periodontics

4210	Gingivectomy or Gingivoplasty – 4+ teeth per quad	100.00
4211	Gingivectomy or Gingivoplasty – 1-3 teeth per quad	40.00
4240	Gingival flap procedure – 4+ teeth per quad	175.00
4241	Gingival flap procedure – 1-3 teeth per quad	105.00
4249	Clinical crown lengthening	125.00

4260	Osseous Surgery - 4+ teeth per quadrant	275.00
4261	Osseous Surgery - 1-3 teeth per quad	135.00
4263	Bone replacement graft - 1st site in quad	125.00
4264	Bone replacement graft - each add'l site in quad	100.00
4270	Pedicle soft tissue graft procedure	150.00
4271	Free soft tissue graft procedure (inc. donor site surgery)	150.00
4320	Provisional splinting - intracoronal	40.00
4321	Provisional splinting - extracoronal	40.00
4341	Perio scaling & root planing – 4+ teeth per quadrant*	25.00
4342	Perio scaling & root planing – 1-3 teeth per quad	15.00
4381	Localized delivery of antimicrobial agents (4 per yr)	75.00
4910	Perio maintenance procedures (following active therapy)	35.00

Prosthodontics (removable)

5110	Complete upper dentures*	300.00
5120	Complete lower dentures*	300.00
5130	Immediate upper dentures*	300.00
5140	Immediate lower dentures*	300.00
5211	Maxillary partial denture - resin base*	300.00
5212	Mandibular partial denture - resin base*	300.00
5213	Maxillary partial denture - cast metal frame/resin base*	300.00
5214	Mandibular partial denture - cast metal frame/resin base*	300.00
5281	Removable unilateral partial denture - one piece cast metal (including clasps & pontics)*	300.00
5410	Adjust complete denture - maxillary	20.00
5411	Adjust complete denture - mandibular	20.00
5421	Adjust partial denture - maxillary	20.00
5422	Adjust partial denture - mandibular	20.00
5610	Repair resin denture base	30.00
5620	Repair cast framework	30.00
5630	Repair or replace broken clasp	20.00
5640	Replace broken teeth - per tooth	25.00
5650	Add tooth to existing partial denture	40.00
5660	Add clasp to existing partial denture	60.00
5710	Rebase complete maxillary denture	100.00
5711	Rebase complete mandibular denture	100.00
5720	Rebase maxillary partial denture	100.00
5721	Rebase mandibular partial denture	100.00
5730	Reline complete upper denture (chairside)	50.00
5731	Reline complete lower denture (chairside)	50.00
5740	Reline upper partial denture (chairside)	50.00
5741	Reline lower partial denture (chairside)	50.00
5750	Reline complete upper denture (laboratory)	100.00

**Perio Scaling and Root Planing 4+ teeth per quadrant only once every three years.*

5751 Reline complete lower denture (laboratory) 100.00
5760 Reline upper partial denture (laboratory) 100.00
5761 Reline lower partial denture (laboratory) 100.00
5862 Precision attachment, by report 50.00
** Prosthetics can only be replaced once every five years.*

Implant Benefit
*6010 Surgical placement of implant body: endosteal implant ..... ***
*6040 Surgical placement: eposteal implant ..... ***
*6050 Surgical placement: transosteal implant ..... ***
***100% up to $1500 pd per procedure/$2000 Lifetime Benefit Max*

Implant Supported Prosthetics
6053, 6054*, 6056*,6057* 350.00*
6058, 6059*, 6060*, 6061*, 6062*, 6063*, 6064*, 6065*,*
6066, 6067*, 6068*, 6069*, 6070*, 6071*, 6072*, 6073*,*
6074, 6075*, 6076*, 6077* 550.00*

Prosthodontics (fixed)
6210 Pontic - cast high noble metal 100.00*
6211 Pontic - cast predominantly base metal 100.00*
6212 Pontic - cast noble metal 100.00*
6240 Pontic - porcelain fused to high noble metal 225.00*
6241 Pontic - porcelain fused to predominantly base metal 225.00*
6242 Pontic - porcelain fused to noble metal 225.00*
6250 Pontic - resin with high noble metal 125.00*
6251 Pontic - resin with predominantly base metal 125.00*
6252 Pontic - resin with noble metal 125.00*
*6545 Retainer - cast metal * 250.00*
6720 Crown - resin with high noble metal 200.00*
6721 Crown - resin with predominantly base metal 200.00*
6722 Crown - resin with noble metal 200.00*
6750 Crown - porcelain fused to high noble metal 275.00*
6751 Crown - porcelain fused to predominantly base metal 275.00*
6752 Crown - porcelain fused to noble metal 275.00*
6780 Crown - 3/4 cast high noble metal 175.00*
6790 Crown - full cast high noble metal 275.00*
6791 Crown - full cast predominantly base metal 250.00*
6792 Crown - full cast noble metal 250.00*
6930 Recement partial dentures 35.00
6950 Precision attachment 100.00
6980 Fixed partial denture repair, by report 50.00
** Prosthetics can only be replaced once every five years*

Oral Surgery - including local anesthesia and post operative care

7111	*Extraction, coronal remnants – deciduous tooth*	*40.00*
7140	*Extraction , erupted tooth or exposed root*	*40.00*
7210	*Surgical removal of erupted tooth requiring elevation mucoperiosteal flap and removal of bone and/or section of tooth*	*70.00*
7220	*Removal of impacted tooth - soft tissue*	*125.00*
7230	*Removal of impacted tooth - partially bony*	*150.00*
7240	*Removal of impacted tooth - completely bony*	*200.00*
7241	*Removal of impacted tooth - completely bony w/complications*	*225.00*
7250	*Surgical removal of residual roots (cutting procedure)*	*35.00*
7310	*Alveoplasty w/extractions – per quadrant*	*60.00*
7320	*Alveoloplasty no extractions- per quadrant*	*50.00*
7440	*Excision of malignant tumor - lesion diameter up to 1.25 cm*	*40.00*
7441	*Excision of malignant tumor - lesion diameter over 1.25 cm*	*40.00*
7510	*Incision & drainage of abscess - intraoral soft tissue*	*25.00*
7520	*Incision & drainage of abscess - extraoral soft tissue*	*20.00*
7960	*Frenulectomy*	*75.00*

Orthodontics

8080	*Comprehensive orthodontic treatment of the adolescent dentition (once per lifetime)*	*500.00*
8090	*Comprehensive orthodontic treatment of the adult dentition (once per lifetime)*	*500.00*
8660	*Pre-orthodontic treatment visit (once per lifetime)*	*150.00*
8670	*Periodic orthodontic treatment visit as part of contract (up to 24 consecutive months)*	*60.00*
8680	*Orthodontic retention -limit $200 (100 ea. top & bottom)*	*100.00*

Adjunctive General Services

9110	*Palliative (emergency) treatment of dental pain*	*20.00*
9220	*General anesthesia - first 30 minutes*	*100.00*
9221	*General anesthesia - each additional 15 minutes*	*50.00*
9310	*Consultation*	*30.00*
9951	*Occlusal adjustment - limited*	*20.00*
9952	*Occlusal adjustment - complete*	*50.00*

LOCAL 1180 BENEFITS FUNDS

SCHEDULED DENTAL BENEFIT PLAN

ENROLLMENT FORM

6 Harrison Street, New York, NY 10013-2898
(212) 966-5353 Out-Of Area (888) 966-5353

Active ☐ Retired ☐

1. _____ 2. SSN or ID# _____
Last Name First Name MI

3. Home Address _____
_____ 4. _____
City State ZIP Home Phone No.

5. Date of Birth _____/_____/_____ 6. Gender: F ☐ M ☐
DD MM YYYY

7. Other Dental Coverage _____ Group # _____

8. Marital Status: Single ☐ Married ☐ Domestic Partnership ☐

Email Address: _____

9. Does Your Spouse/Domestic Partner Have Other Dental Coverage: Yes ☐ No ☐

Spouse's/Domestic Partner's Insurance Carrier _____ Group # _____

10. List below the names of your spouse/partner and dependents eligible for dental benefits under the Scheduled Dental Benefit Plan: (Dependent children under 19 yrs of age/23 yrs of age if full-time student)

Last Name	First Name	MI	SSN	Relationship (Circle)					Date of Birth
				H	W	P	D	S	MM / DD /YYYY
				H	W	P	D	S	MM / DD / YYYY
				H	W	P	D	S	MM / DD / YYYY
				H	W	P	D	S	MM / DD / YYYY
				H	W	P	D	S	MM / DD / YYYY
				H	W	P	D	S	MM / DD / YYYY

MEMBER'S SIGNATURE _____ DATE _____

How to Enroll?

1. Complete the enrollment application above entirely and be sure to sign and date where indicated.
2. Insert the application in the enclosed return envelope and mail to the address displayed above.

NOTE: Be sure to mail with the proper postage. Your Annual Open Enrollment Application must be received by the Fund Office no later than Friday, December 14th, 2018.

ENROLLMENT APPLICATION

CWA LOCAL 1180 BENEFIT FUNDS
6 HARRISON STREET
NEW YORK, NY 10013
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