

**NEW YORK CITY RETIREES HEALTH AND WELFARE FUND
PLAN DESCRIPTION AND FEE SCHEDULE**

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	<ul style="list-style-type: none"> Eligibility is determined according to the definition and requirements outlined in the New York City Retirees Health and Welfare Fund. Eligible dependents include the lawful spouse, domestic partner and unmarried children until they reach the age 19, unmarried children who are full-time students until they reach the age 23 or graduate, whichever comes first.
PLAN YEAR	<ul style="list-style-type: none"> January 1 st through December 31 st
PLAN MAXIMUM	<ul style="list-style-type: none"> \$2,000 annual maximum
DEDUCTIBLE	<ul style="list-style-type: none"> There is no deductible
PLAN LIMITATIONS	<ul style="list-style-type: none"> Examination – two per calendar year Prophylaxis – two per calendar year X-rays – Full mouth series or Panoramic Film – once every 36 months Bitewings – once every 6 months 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 14 Fluoride treatment – to age 19, maximum once per calendar year Root Scaling, curettage, bite correction; any combination, including prophylaxis – once every six months. Periodontal Surgery – charting and x-ray required; 1 in 12 consecutive months
PRE-TREATMENT REVIEW	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Covered and reimbursable services: None Covered but not reimbursable services: Schedule allowance Non-covered services: Your usual charge for that service
COORDINATION OF BENEFITS	<ul style="list-style-type: none"> When both the member and spouse have dental coverage they are primary for themselves. Benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. If a dependent child is covered by plans of both parents, the benefits of the plan which covers the child of the parent whose date of birth (month and day only, excluding year) occurs earlier in the calendar year, will be determined to be the primary payer.
HOW TO FILE A CLAIM	<ul style="list-style-type: none"> 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 138 P.O. Box 9005 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

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**NYC RETIREES WELFARE FUND
OUT OF NETWORK PROVIDER SCHEDULE OF ALLOWANCES**

NO OUT OF POCKET EXPENSE FOR MEMBERS UTILIZING PPO PROVIDERS

	PLAN PAYS		PLAN PAYS
<u>I-DIAGNOSTIC</u>		<u>V-PERIODONTICS</u>	
PERIODIC ORAL EXAM	32.00	GINGIVECTOMY-PER QUAD	641.00
X-RAYS (FULL MOUTH SERIES)	100.00	OSSEOUS SURGERY-PER QUAD	218.00
PERIAPICAL X-RAY FIRST FILM	13.00	OSSEOUS GRAFT-SINGLE SITE	74.00
PERIAPICAL X-RAY - EACH ADDITIONAL	10.00	OSSEOUS GRAFT-ADDITIONAL	74.00
BITEWING X-RAY - SINGLE FILM	12.00	SCALING AND ROOT PLANING-PER QUAD	67.00
BITEWING X-RAY - TWO FILMS	21.00	PERIODONTAL MAINTENANCE	209.00
BITEWING X-RAY - THREE FILMS	25.00	PEDICLE SOFT TISSUE GRAFT	300.00
BITEWING X-RAY - FOUR FILMS	31.00	FREE SOFT TISSUE GRAFT	73.00
OCCLUSAL FILM	13.00	SPLINTING INTRACORONOL	199.00
POSTERIOR-ANTERIOR OR LATERAL FILM	38.00	SPLINTING EXTRACORONOL	
PANORAMIC FILM	61.00		
DIAGNOSTIC CASTS	36.00	<u>VI-ORAL SURGERY</u>	106.00
		SIMPLE EXTRACTION	144.00
<u>II-PREVENTIVE</u>		SURGICAL EXTRACTION	144.00
PROPHYLAXIS-Adult	54.00	IMPACTION-SOFT TISSUE	185.00
PROPHYLAXIS-Child	54.00	IMPACTION-PARTIAL BONY	239.00
FLUORIDE EXCL. PROPHY	29.00	IMPACTION-COMPLETE BONY	88.00
SEALANT-per quad	15.00	SURGICAL EXPOSURE-(aid eruption)	113.00
SPACE MAINTAINER-fixed unilateral	156.00	BIOPSY-SOFT TISSUE	120.00
SPACE MAINTAINER-fixed bilateral	156.00	CYST/TUMOR REMOVAL < 1.25cm	64.00
		PALLIATIVE TREATMENT	117.00
<u>III-RESTORATIVE</u>		ALVEOPLASTY-PER QUAD	74.00
AMALGAM - 1 SR-Primary	66.00	INCISION AND DRAINAGE-no other treatment	
AMALGAM - 2 SRF-Primary	85.00		
AMALGAM - 3 SRF-Primary	105.00	<u>VII-PROSTHODONTICS</u>	695.00
AMALGAM- 4 + Surfaces Primary	175.00	COMPLETE DENTURE UPPER OR LOWER	695.00
AMALGAM - 1 SR-Permanent	66.00	IMMEDIATE DENTURE UPPER OR LOWER	463.00
AMALGAM - 2 SRF-Permanent	85.00	PARTIAL DENTURE-ACRYLIC BASE	846.00
AMALGAM - 3 SRF-Permanent	105.00	UPPER OR LOWER PARTIAL CAST METAL	
AMALGAM- 4 + Surfaces-Permanent	175.00	UNILATERAL PARTIAL DENTURE	200.00
RESIN-1 SURFACE	67.00	ONE TOOTH	103.00
RESIN-2 SURFACE	80.00	REPAIR BROKEN COMPLETE DENTURE	86.00
RESIN-3 SURFACE	107.00	REPAIR OR REPLACE CLASP	160.00
INCISAL RESIN 4+ SRF OR INCISAL EDGE	142.00	REPAIR CAST FRAMEWORK	87.00
METALLIC INLAY-1 SRF	200.00	REPLACE BROKEN TTH	167.00
METALLIC INLAY-2 SRF	250.00	RELINE FULL DENTURE-CHAIRSIDE	145.00
METALLIC INLAY-3 SRF	560.00	RELINE PARTIAL DENTURE-CHAIRSIDE	160.00
CROWN-RESIN	174.00	RELINE FULL DENTURE-LABORATORY	198.00
CROWN-RESIN TO METAL	375.00	RELINE PARTIAL DENTURE-LABORATORY	168.00
CROWN-PORCELAIN	508.00	PONTIC-CAST METAL	580.00
CROWN-PORCELAIN TO METAL	565.00	PONTIC-PORCELAIN TO METAL	378.00
CROWN-FULL CAST	574.00	PONTIC-RESIN TO METAL	580.00
CROWN-FULL CAST METAL	445.00	ABUTMENT-FUSED TO METAL	400.00
LABIAL LAMINATE	251.00	ABUTMENT-RESIN WITH METAL	210.00
CAST POST AND CORE	202.00	ABUTMENT-PORCELAIN WITH JACKET	137.00
PREFAB POST AND CORE	186.00	ABUTMENT-FULL METAL	108.00
RECEMENT CROWN	49.00	RECEMENT BRIDGE	
		<u>VIII-ADJUNCTIVE SERVICES</u>	64.00
<u>IV-ENDODONTICS</u>		PALLIATIVE TREATMENT	87.00
PULP CAP DIRECT	20.00	GENERAL ANESTHESIA - first 30 minutes only	87.00
VITAL PULPOTOMY	67.00	IV SEDATION - first 30 minutes only	28.00
ROOT CANAL THERAPY-1 CANAL	350.00	SPECIALIST CONSULTATION	54.00
ROOT CANAL THERAPY-2 CANALS	425.00		
ROOT CANAL THERAPY-3 CANALS	600.00		
RETROGRADE FILLING	86.00		
APICOECTOMY	134.00		
HEMISECTION	150.00		
ROOT RESECTION	150.00		