COUNCIL OF SUPERVISORS & ADMINISTRATORS
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.

CSA DAYCARE COUNCIL Dept. 17

ELIGIBILITY	• CSA - Active School Principals, Assistant Principals, Administrators and Supervisors who are or were employed by the New York City Board of Education. Include the lawful spouse and each dependent child from birth until the age of 26 is reached so long as they are not covered by or eligible for other health insurance through their employer and have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
ANNUAL MAXIMUM	• $7,500 calendar year maximum for all dental benefits.
ORTHODONTIC MAXIMUM	• The lifetime maximum benefit for orthodontic services is $3,300 for CSA Active . Orthodontic treatment is subject to the annual maximum and deductible.
DEDUCTIBLE	• $25 per person, per calendar year, waived on diagnostic and preventive services.
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** - $48 maximum per calendar year • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Sealant** – unrestored posterior teeth, lifetime maximum one application per tooth, to age 18 • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – per • visit, maximum $150 per calendar year • **Periodontal Maintenance** – included in periodontal maximum, payable only after surgery • **Periodontal surgery –** Max $1000 per calendar year**,** charting and x-rays required; not more then once in 3 years • **Orthodontics –** maximum 24 months of active treatment, $1650 total max • **Specialist consultation –** two per year, no other treatment that same visit, includes allowance for examination
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 co-payment:** None • **Covered and reimbursable services, with co-payment:** Only established co-payments • **Covered but not reimbursable services:** Schedule allowance • **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, deductibles, 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. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : Self-Insured Dental Services, Dept 15 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 (800) 537-1238

Rev 1/17

CSA DAYCARE COUNCIL-SCHEDULE OF ALLOWANCES

	Plan Pays	Co Pay
DIAGNOSTIC & PREVENTIVE		
ORAL EXAM	15	0
FULL MOUTH SERIES	40	0
PANORAMIC X-RAY	36	0
PERIAPICAL OR BITEWING 1st Film	7	0
PERIAPICAL / BITEWING each additional	7	0
EXTRAORAL FILM	30	0
TMJ VIEW	30	0
PROPHYLAXIS	25	0
SPACE MAINTAINER	97	0
PALLIATIVE TREATMENT	20	0
SEALANT	10	0
RESTORATIVE		
AMALGAM-one surface	22	0
AMALGAM-two surface	32	0
AMALGAM-three surfaces	40	0
AMALGAM-four or more surfaces	45	0
COMPOSITE RESIN, one surface	30	0
COMPOSITE RESIN, two surface	31	0
COMPOSITE RESIN, three or more	31	0
RESIN, INCISAL ANGLE	58	0
PIN RETENTION	20	0
METALLIC or PORCELAIN INLAY		
one surface	150	0
two surface	175	0
three or more surfaces	200	0
onlay per tooth	69	0
CAST POST & CORE	90	0
PRE-FAB POST & CORE	60	0
LAMINATE VENEER-LAB	215	50
CROWNS AND BRIDGES		
CROWNS		
acrylic jacket (lab)	150	50
stainless steel (primary tth)	55	0
porcelain jacket	215	50
plastic with metal	270	50
porcelain with metal	295	50
full cast	250	50
3/4 cast	225	50
maryland bridge retainer	225	50
BRIDGE PONTICS		
full cast	250	50
plastic with metal	250	50
porcelain with metal	250	50
RECEMENTATION		
of crown, inlay	17	0
of bridge	22	0
ENDODONTICS		
PULP CAP, direct	14	0
VITAL PULPOTOMY	35	0
ROOT THERAPY		
anterior	151	50
bicuspid	200	50
molar	280	50
APICOECTOMY, 1ST ROOT	125	0
APICOECTOMY, MAX-TTH	200	0
RETROGRADE ROOT FILL	35	0
HEMISECTION/ROOT RESECTION	100	0

	Plan Pays	Co Pay
PERIODONTICS		
PERIODONTAL TREATMENT		
root scaling, subgingival curettage		
bite correction, including prophy-per quad	39	0
maximum per visit	50	0
PERIODONTAL MAINTENANCE	50	0
OSSEOUS GRAFT	99	0
PERIODONTAL SURGERY		
gingivectomy or gingivoplasty		
soft tissue graft, vestibuloplasty,		
any combination, per quad	140	0
OSSEOUS SURGERY	250	50
ORAL SURGERY		
ROUTINE EXTRACTION	30	0
SURGICAL EXTRACTION		
erupted tooth	90	0
retained root	70	0
impaction-soft tissue	100	0
impaction-partial bony	125	0
impaction-complete bony	150	0
EXPOSURE OF IMPACTED		
OR UNERUPTED TOOTH		
to aid eruption	90	0
CYST REMOVAL< 1.25CM	65	0
ALVEOLOPLASTY-per quad	73	0
FRENULECTOMY	65	0
BIOPSY	55	0
DENTURES		
COMPLETE DENTURE		
immediate or permanent	319	50
PARTIAL-ACRYLIC	275	50
UNILATERAL-one tooth	165	50
UNILATERAL-partial	185	50
PARTIAL-CAST	275	50
TISSUE CONDITIONING	38	0
DENTURE REPAIRS		
replace tooth in denture	45	0
repair cast framework	60	0
add or replace clasp	63	0
add tooth to existing partial	65	0
DENTURE RELINE		
complete denture - office	66	0
partial denture - office	66	
complete denture - lab	100	0
partial denture - lab	100	0
ORTHODONTICS		
FIXED APPLIANCE	360	50
REMOVABLE APPLIANCE	131	50
ACTIVE TX-per month	42	0
PASSIVE TX-per 3 months	126	0
RETAINER	75	25
ADJUNCTIVE SERVICES		
GENERAL ANESTHESIA/IV SEDATION-15 min	48.50	0
CONSULTATION	23	50