CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL & FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND
PLAN DESCRIPTION & FEE SCHEDULE

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

ELIGIBILITY	• Eligibility is determined according to the definition and requirements outlined in the Citywide Association of Law Assistants of the Civil, Criminal & Family Courts in the City of New York Welfare Trust Fund Summary Plan Description **Eligible dependents** include the lawful spouse, domestic partners and dependents up to age 26, even if the child is eligible to enroll in another employer sponsored plan. • Part-time employees and Retirees who has less then one year of active service receive 50% of the scheduled allowance.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $3,750 annual maximum **Part-time/Retirees** $1,875 annual maximum
ORTHODONTIC MAXIMUM	• 20 months of active treatment and 18 months of passive treatment
PLAN LIMITATIONS	• **Examination** – 2 per Calendar Year • **Prophylaxis** – 2 per Calendar Year • **X-rays- Full Mouth Series or Panorex** – once every 12 months • **Replacement of prosthetics** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, 2 applications every calendar year • **Sealants** – to age 16, permanent posterior teeth only, maximum 2 per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum 4 times per year • **Periodontal surgery –** charting and x-rays required; once in 36 months • **Rebasing or relining denture** – once in 36 months • **Implants -** 6 Implants per Lifetime
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:** None • **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 150. 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 A.S.O. at:
(516) 396-5500 or (718) 204-7172

Eff. 01/22

CITYWIDE ASSOCIATION OF LAW ASSISTANTS WELFARE FUND
SCHEDULE OF ALLOWANCES

	MAXIMUM CHARGE
I-DIAGNOSTIC	
ORAL EXAM	60.00
X-RAYS (FULL MOUTH SERIES)	87.00
PERIAPICAL X-RAY FIRST FILM	14.00
PERIAPICAL X-RAY - EACH ADDITIONAL	11.00
BITEWING X-RAY - SINGLE FILM	12.00
BITEWING X-RAY - TWO FILMS	17.00
BITEWING X-RAY - FOUR FILMS	37.00
OCCLUSAL FILM	33.00
PANORAMIC FILM	74.00
CEPHALOMETRIC FILM	85.00
TEMPOROMANDIBULAR FILM	57.00
CONE BEAM	250.00
PULP VITALITY TEST	35.00
DIAGNOSTIC CASTS	75.00
II-PREVENTIVE	
PROPHYLAXIS-Adult	100.00
PROPHYLAXIS-Child	90.00
FLUORIDE EXCL. PROPHY	29.00
SEALANT	38.00
SPACE MAINTAINER-fixed unilateral	273.00
SPACE MAINTAINER-fixed bilateral	360.00
III-RESTORATIVE	
AMALGAM - 1 SURFACE	120.00
AMALGAM - 2 SURFACES	145.00
AMALGAM - 3 SURFACES	175.00
AMALGAM- 4 + SURFACES	186.00
RESIN-1 SURFACE POSTERIOR	155.00
RESIN-2 SURFACE POSTERIOR	190.00
RESIN-3 SURFACE POSTERIOR	230.00
RESIN 4+ SURFACE POSTERIOR	230.00
RESIN-1 SURFACE ANTERIOR	140.00
RESIN-2 SURFACE ANTERIOR	165.00
RESIN-3 SURFACE ANTERIOR	190.00
INCISAL ANGLE ANTERIOR	220.00
METALLIC INLAY-1 SRF	551.00
METALLIC INLAY-2 SRF	625.00
METALLIC INLAY-3 SRF	720.00
METALLIC ONLAY-2 SRF	706.00
METALLIC ONLAY-3 SRF	739.00
METALLIC ONLAY-4 SRF	768.00
INLAY-PORCELAIN 2 SURFACES	625.00
INLAY-PORCELAIN 3 SURFACES	720.00
CROWN-PLASTIC	329.00
CROWN-PORCELAIN	880.00
CROWN-PORCELAIN TO METAL	870.00
CROWN-FULL CAST	840.00
CROWN-3/4 CAST	787.00
PORCELAIN LAMINATE - chairside	672.00
CAST POST AND CORE	325.00
PREFAB POST AND CORE	280.00
RECEMENT CROWN	100.00
RECEMENT INLAY	85.00
PREFAB SS CROWN-primary teeth only	188.00
IV-ENDODONTICS	
PULP CAP-DIRECT	44.00
PULP CAP-INDIRECT	35.00
VITAL PULPOTOMY	104.00
ROOT CANAL THERAPY-ANTERIOR	750.00
ROOT CANAL THERAPY-BICUSPID	900.00
ROOT CANAL THERAPY-MOLAR	1,000.00
POST REMOVAL	225.00
RETREAT ROOT CANAL-ANTERIOR	850.00
RETREAT ROOT CANAL-BICUSPID	1,000.00
RETREAT ROOD CANAL-MOLAR	1,200.00
RETROGRADE FILLING	153.00
APICOECTOMY-FIRST ROOT, BICUSPID	525.00
APICOECTOMY-FIRST ROOT, MOLAR	622.00
APICOECTOMY- EACH ADDITIONAL ROOT	257.00
ROOT RESECTION	250.00

	MAXIMUM CHARGE
V-PERIODONTICS	
GINGIVECTOMY-PER QUAD	446.00
OSSEOUS SURGERY-PER QUAD	750.00
OSSEOUS GRAFT-SINGLE SITE	300.00
OSSEOUS GRAFT - ADDITIONAL	200.00
GUIDED TISSUE REGEN-RESORB	200.00
PEDICLE SOFT TISSUE GRAFTS	400.00
FREE SOFT TISSUE GRAFTS-QUAD	400.00
OCCLUSAL ADJUSTMENT-LIMITED	50.00
LOCALIZED DELIV. OF CHEMO. AGENT	60.00
CURETTAGE, SCALE\ROOT PLANING-per quad	175.00
FULL MOUTH DEBRIDEMENT	125.00
PERIODONTAL MAINTENANCE PROCEDURE	115.00
VI-ORAL SURGERY	
SIMPLE EXTRACTION	150.00
SURGICAL EXTRACTION	250.00
IMPACTION-SOFT TISSUE	300.00
IMPACTION-PARTIAL BONY	375.00
IMPACTION-COMPLETE BONY	420.00
IMPACTION-COMPLETE BONY W/ COMPLICATIONS	525.00
REMOVAL OF RESIDUAL ROOT	200.00
SURG.EXP-IMP/UNERUP(FOR ORTHO)	350.00
SURG.EXP-IMP/UNERUP(AID ERUPT)	250.00
BIOPSY HARD TISSUE	811.00
BIOPSY SOFT TISSUE	333.00
CYST/TUMOR REMOVAL <1.25	722.00
CYST/TUMOR REMOVAL >1.25	1,134.00
ALVEOPLASTY-PER QUAD	328.00
FRENULECTOMY	202.00
BONE GRAFT PERIRADICULLAR SURG	200.00
BONE REPLACEMENT GRAFT FOR RID	500.00
VII-PROSTHODONTICS	
COMPLETE DENTURE	1,000.00
IMMEDIATE DENTURE	1,000.00
PARTIAL DENTURE-ACRYLIC BASE	950.00
PARTIAL DENTURE-CAST METAL BASE	1,200.00
REPAIR ACRYLIC SADDLE OR BASE	103.00
REPAIR OR REPLACE CLASP	114.00
ADD TOOTH TO PARTIAL	150.00
REPAIR CAST FRAMEWORK	134.00
REPLC MISS/BRKN TTH-COM DENT	150.00
RELINE FULL UPPER DENTURE-CHAIRSIDE	198.00
RELINE PARTIAL DENTURE-CHAIRSIDE	130.00
RELINE COMPLETE UP/LOW DENTURE - LAB	225.00
RELINE PARTIAL UP/LOW DENTURE - LAB	250.00
ADJUST PARTIAL UPPER DENTURE	45.00
PONTIC-PORCELAIN TO METAL	800.00
PONTIC-RESIN WITH METAL	775.00
ABUTMENT-PORCELAIN WITH METAL	850.00
ABUTMENT-FULL CAST	815.00
ENDOSTEAL IMPLANT	1,750.00
CUSTOM ABUTMENT	650.00
ABUTMENT SUPPORTED CROWN	900.00
IMPLANT SUPPORTED CROWN	1,050.00
MARYLAND BRIDGE RETAINER	500.00
VIII-ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT	59.00
GENERAL ANESTHESIA - first 15 minutes only	125.00
GENERAL ANESTHESIA ADDITIONAL	125.00
IV SEDATION - per 15 minutes	93.00
ANALGESIA	41.00
LOCAL ANESTHESIA	19.00
SPECIALIST CONSULTATION	124.00
IX-ORTHODONTICS	
DIAGNOSIS & INITIAL INSERTION	825.00
ACTIVE ORTHO VISIT- maximum 20 months	165.00
PASSIVE VISITS- PER 6 MONTHS- maximum 18 mths	165.00
RETAINER	275.00

REVISED 1/22