UNITED PUBLIC SERVICE EMPLOYEES BENEFIT PLAN
CARLE PLACE CLERICAL SCHOOL DISTRICT
PLAN DESCRIPTION & FEE SCHEDULE

Members of the Carle Place Clerical School District are now affiliated with United Public Service Employees Benefit Plan, but still have access to the Local 153 PPO Network.

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

ELIGIBILITY	• Individuals who are in Covered Employment under the provisions of a collective bargaining agreement with the **United Public Service Employees Benefit Plan.** Retirees meeting eligibility requirements are also covered • **Eligible dependents**: Include the spouse and, unmarried dependent children who have not yet reached their 19th birthday. Coverage is extended until the 23rd birthday for unmarried dependent children attending school full-time. Unmarried children incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation, or physical handicap; will continue to be eligible.
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• $2,000 per covered individual in a calendar year
DEDUCTIBLE	• There is no deductible
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Replacement of crowns, bridge, dentures** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride Treatment –** to age 15, once per calendar year • **Sealant –** unrestored permanent posterior teeth to age 19 once per tooth per lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – Maximum $180 in a calendar year • **Orthodontic treatment max –** Adults $2,000-24 months, Child $2,780-36 months
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-payment • **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 and customary charges and benefits from the other plan must first be applied to reduce to eliminate any charges incurred due to co-payments, plan maximums or frequency limitations.
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. **Signature on file is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting\ • Claims are processed by SIDS. Claim forms must first be sent to Local 153 for eligibility verification. • Mail claims to : Self-Insured Dental Services, Dept. 149 P.O. Box 9005 Lynbrook, NY 11563 • File claims electronically: **PAYOR ID: CX076**

For up to date detailed information 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

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Self-Insured Dental Services / Administrative Services Only, Inc. Dental Plan Administrators

UPSEBP-CARLE PLACE CLERICAL SCHOOL DISTRICT
SCHEDULE OF ALLOWANCES

DIAGNOSTIC & PREVENTIVE	MAXIMUM CHARGE
ORAL EXAM	17.00
FULL MOUTH SERIES	40.00
PANORAMIC X-RAY	40.00
PERIAPICAL X-RAY	5.00
BITEWING X-RAY	5.00
OCCLUSAL FILM	10.00
EXTRAORAL OR TMJ FILM	25.00
CEPHALOMETRIC FILM	40.00
PROPHYLAXIS - ADULT	30.00
PROPHYLAXIS - CHILD	25.00
FLOURIDE EXCL PROPHY	10.00
SEALANT-PER TTH	15.00
SPACE MAINTAINER	150.00
PALLIATIVE TREATMENT	30.00
RESTORATIVE	
SILVER AMALGAM FILLINGS	
PRIMARY OR PERMANENT	
one surface	45.00
two surfaces	55.00
three surfaces	60.00
four or more	65.00
COMPOSITE RESIN FILLINGS	
one surface	52.00
two surfaces	60.00
three or more surfaces	70.00
BONDED RESIN, INCISAL ANGLE	80.00
PIN RETENTION	25.00
METALLIC INLAY or ONLAY	
one surface	200.00
two surface	230.00
three or more surfaces	260.00
CAST POST & CORE	125.00
PRE-FAB POST & CORE	75.00
LAMINATE VENEER	275.00
CROWNS	
acrylic jacket (lab processed)	175.00
stainless steel (primary tooth)	75.00
porcelain jacket	350.00*
plastic with metal	375.00*
porcelain with metal	425.00*
full cast	350.00*
3/4 cast	350.00*
RECEMENTATION	
crown or inlay	30.00
bridge or space maintainer	40.00
ENDODONTICS	
PULP CAP	10.00
VITAL PULPOTOMY	60.00
ROOT THERAPY	
one canal	225.00
two canals	275.00
three canals	350.00
APICOECTOMY, FIRST ROOT	150.00
APICOECTOMY, MAX PER TOOTH	300.00
RETROGRADE ROOT FILLING	85.00

*** INCLUDES A $75 MEMBER CO-PAYMENT**

PERIODONTICS	MAXIMUM CHARGE
PERIODONTAL TREATMENT	
root scaling, subgingival curettage	
bite correction, including prophy	
per visit	50.00
full mouth	60.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00
PERIODONTAL SURGERY-per quad	
gingivectomy or gingivoplasty,	
soft tissue graft, vestibuloplasty,	
any combination	125.00
osseous surgery	350.00
OSSEOUS GRAFT-single site	90.00
OSSEOUS GRAFT-multiple site	250.00
ORAL SURGERY	
ROUTINE EXTRACTION	50.00
SURGICAL EXTRACTION	
erupted tooth	75.00
retained root	60.00
impaction-soft tissue	115.00
impaction-partial bony	185.00
impaction-complete bony	225.00
SURGICAL EXPOSURE OF IMPACTED	
OR UNERUPTED TOOTH	80.00
CYST REMOVAL < 1.25	75.00
CYST REMOVAL > 1.25	125.00
FRENULECTOMY	95.00
ALVEOLOPLASTY-per quad	125.00
INCISE AND DRAIN	50.00
BIOPSY	75.00
ROOT RESECTION	70.00
HEMISECTION	150.00
PROSTHODONTICS	
COMPLETE DENTURE	
immediate or permanent	600.00
PARTIAL DENTURE-ACRYLIC BASE	425.00
unilateral-one tooth	200.00
PARTIAL DENTURE-CAST CHROME	400.00
BRIDGE PONTICS	
full cast	350.00*
plastic with metal	375.00*
porcelain with metal	425.00*
MARYLAND BRIDGE RETAINER	230.00
PRECISION ATTACHMENT	75.00
DENTURE REPAIRS	
broken denture base	65.00
repair partial acrylic saddle/base	90.00
replace miss/brkn tooth in denture	85.00
replace broken facing	100.00
add or replace clasp	85.00
repair cast framework	100.00
DENTURE RELINE	
complete denture - office	80.00
partial denture - office	75.00
complete denture - lab	125.00
partial denture - lab	100.00
ORTHODONTICS	
INITIAL ORTHODONTIC APPLIANCE	
full treatment-fixed appliance	480.00
ACTIVE TREATMENT-per month	60.00
PASSIVE TREATMENT-per 3 months	60.00
RETAINER APPLIANCE	125.00
HARMFUL HABIT APPLIANCE	135.00