ASSOCIATION OF SURROGATE AND SUPREME COURT REPORTERS WELFARE FUND
ASSCR/METRODENT PREMIER PLUS 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.

ELIGIBILITY	• All official City of New York senior court reporters and retirees who are covered by the Association of Surrogates and Supreme Court Reporters Collective Bargaining Agreement are eligible for dental benefits. • Eligible dependents will be covered up to age 26.
PLAN YEAR	• July 1 st through June 30 th
PLAN MAXIMUM	• $3,000 per covered individual in a plan year
DEDUCTIBLE	• There is no plan deductible
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – **panoramic or full mouth series –** one in a three year period • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 16, one application per year • **Sealant –** to age 16, permanent unrestored molar, maximum two applications in a lifetime • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $450 per calendar year • **Replacement of crowns, bridges and dentures –** not more than once in 5 years • **Orthodontic treatment –** Lifetime maximum amount payable under the plan is $4,000 per covered individual • **Specialist consultation –** one per calendar year, includes examination allowance • **Denture Adjustment –** one in a calendar year • **Missing Tooth Clause –** bridge or denture that replaces a tooth missing before the individual became eligible for dental benefits provided by the Welfare Fund will not be payable unless the person is covered for such benefits for 24 consecutive months. • **Implants –**2 per year • **General anesthesia/IV sedation -** per 15 minutes, maximum 30 minutes
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 surcharge permitted • **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 & customary charge.
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 • Mail claims to : Self-Insured Dental Services, Dept 24. 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

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

ASSOCIATION OF SURROGATES AND SUPREME COURT REPORTERS
SCHEDULE OF ALLOWANCES

	PLAN MAXIMUM
DIAGNOSTIC & PREVENTIVE	
ORAL EXAM	25.00
FULL MOUTH SERIES	60.00
PERIAPICAL or BITEWING X-RAY 1st film	10.00
PERIAPICAL- each additional film	6.00
OCCLUSAL FILM	15.00
PANORAMIC FILM	50.00
EXTRA ORAL FILM-TMJ, CEPHALOMETRIC	50.00
PROPHYLAXIS-adult	45.00
PROPHYLAXIS-child	35.00
SEALANT	25.00
PALLIATIVE TREATMENT	40.00
SPECIALIST CONSULTATION	65.00
SPACE MAINTAINER	185.00
RESTORATIVE	
AMALGAM one surface	55.00
AMALGAM two surface	70.00
AMALGAM three surface	80.00
AMALGAM four or more surface	95.00
COMPOSITE RESIN-one srf-anterior	60.00
COMPOSITE RESIN-two srf-anterior	75.00
COMPOSITE-three or more srf-anterior	90.00
RESIN-four or more or INCISAL ANGEL	100.00
COMPOSTE RESIN-one srf-posterior	75.00
COMPOSITE RESIN-two srf-posterior	100.00
COMPOSITE RESIN-three srf-posterior	115.00
COMPOSITE RESIN-four or more srf-posterior	125.00
PIN RETENTION	30.00
INLAY one surface	275.00
INLAY two surface	350.00
INLAY three or more surfaces	375.00
CAST POST & CORE	160.00
PRE-FAB POST & CORE	120.00
LAMINATE VENEER	375.00
CROWNS AND BRIDGES	
CROWNS	
acrylic jacket (lab)	200.00
stainless steel (primary tth)	100.00
porcelain jacket	550.00
porcelain with metal	625.00
full cast	500.00
3/4 cast	500.00
maryland bridge retainer	330.00
BRIDGE PONTICS	
full cast	500.00
plastic with metal	525.00
porcelain with metal	550.00
RECEMENTATION	
crown	40.00
bridge	50.00
ENDODONTICS	
PULP CAP	30.00
VITAL PULPOTOMY	80.00
ROOT THERAPY-one canal	350.00
ROOT THERAPY-two canals	425.00
ROOT THERAPY-three canals	600.00
RETREAT ROOT CANAL-anterior	450.00
RETREAT ROOT CANAL-bicuspid	525.00
RETREAT ROOT CANAL-molar	700.00
APICOECTOMY 1ST ROOT	250.00
APICOECTOMY-each additional root	150.00
RETROGRADE ROOT FILL	100.00
HEMISECTION ROOT RESECTION	200.00

	PLAN MAXIMUM	PLAN PAYS	MEMBER CO-PAY
PERIODONTICS			
ROOT SCALING			
subgingival curett, bite correction, including prophy			
per visit	75.00		
1-3 teeth	45.00		
PERIODONTAL MAINTENANCE	65.00		
SUBEPITHELIAL CONNECTIVE TISSUE GRAFT	600.00		
OSSEOUS GRAFT	150.00		
GINGIVECTOMY-per quad	250.00		
OSSEOUS SURGERY-per quad	525.00		
FREE SOFT TISSUE GRAFT	300.00		
ORAL SURGERY			
ROUTINE EXTRACTION	70.00		
EXTRACTION OF CORONAL REMAINS	65.00		
SURGICAL EXTRACTION			
erupted tooth	100.00		
retained root	110.00		
impaction-soft tissue	150.00		
impaction-complete bony	275.00		
REMOVAL OF EXOSTOSIS-per quad	150.00		
INCISION & DRAINAGE,intraoral	75.00		
EXPOSURE OF IMPACTED OR UNERUPTED TOOTH			
to aid eruption	200.00		
CYST REMOVAL - up to 1/2 inch	125.00		
CYST REMOVAL-larger than 1/2 inch	200.00		
ALVEOLOPLASTY-per quad	140.00		
FRENULECTOMY	150.00		
BIOPSY OF ORAL HARD TISSUE	150.00		
GENERAL ANESTHESIA or IV per 15 mnts, max 30	85.00		
DENTURES			
COMPLETE DENTURE			
immediate or permanent	725.00		
PARTIAL-ACRYLIC WITH CLASPS & RESTS	550.00		
REMOVABLE UNILATERAL	275.00		
PARTIAL-CAST METAL BASE	750.00		
DENTURE ADJUSTMENT-*max one per year*	40.00		
TISSUE CONDITIONING	75.00		
BROKEN DENTURE BASE	100.00		
REPAIR ACRYLIC SADDLE/BASE	90.00		
BROKEN CAST FRAMEWORK	100.00		
REPLACE TOOTH IN DENTURE	90.00		
REPLACE BROKEN FACING	100.00		
ADD CLASP	105.00		
REPLACE CLASP	90.00		
REATTACH CLASP	90.00		
ADD TOOTH TO EXISTING PARTIAL	90.00		
DENTURE RELINE			
complete denture - office	120.00		
partial denture - office	105.00		
complete denture - lab	165.00		
partial denture - lab	150.00		
ENDOSTEAL IMPLANT	1200.00	600.00	600.00
ABUTMENT SUPP PORC/METAL CROWN	750.00	550.00	200.00
CUSTOM IMPLANT ABUTMENT	500.00	375.00	125.00
PRE-FABRICATED IMPLANT ABUTMENT	500.00	250.00	250.00
ORTHODONTICS			
DIAGNOSIS & INITAL APPLIANCE	1000.00		
INTERCEPTIVE ORTHO TX TRANSITIONAL DEN	500.00		
ACTIVE TX-per month	100.00		
PASSIVE TX- per 3 months	100.00		
POST TREATMENT STABILIZATION DEVICE	150.00		

REV 9/19