# HASTINGS AUXILIARY PERSONEL BENEFIT FUND
# 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.

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| **ELIGIBILITY** | • All employees who are eligible for benefits according to the provision of the Rules of Eligibility of the Hastings Association of Office and Auxiliary Personnel and Hastings Custodial staff. **Eligible dependents** include spouses, unmarried children who have not yet attained their 19th birthday or 26th birthday if attending an accredited school or college on a full-time basis. |
| **PLAN YEAR** | • September 1 – August 31 |
| **ANNUAL MAXIMUM** | • 2,500 per family in a plan year |
| **DEDUCTIBLE** | • None |
| **PLAN LIMITATIONS** | • **Examination** – four in a plan year<br>• **Prophylaxis** – four in a plan year<br>• **X-rays** – **panoramic or full mouth series –** one in thirty six months<br>• **Replacement of prosthetics** – not more than once in five years<br>• **Palliative treatment** – no other treatment rendered that same visit<br>• **Sealant** – unrestored posterior teeth, to age 19, lifetime maximum two applications per tooth.<br>• **Fluoride treatment** – to age 19, maximum two applications per year<br>• **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – per visit, maximum $260 per calendar year<br>• **Periodontal Maintenance –**subject to the periodontal maximum, payable only after surgery<br>• **Periodontal surgery –** charting and x-rays required; 1 in 36 consecutive months<br>• **Specialist consultation –** once per 12 consecutive months, no other treatment that same visit, includes allowance for examination<br>• **Implants-** $500 one per year two per jaw in a lifetime. Not accepted as payment in full for in network providers. |
| **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<br>• Pre-op periapical x-rays required for crowns, veneers, inlays and extractions<br>• Periodontal charting and x-rays are required for surgical periodontal procedures<br>• Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework |
| **PERMISSIBLE CHARGES** | • **Covered and reimbursable services:** None<br>• **Covered but not reimbursable services:** Schedule allowance<br>• **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.**<br>• 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.**<br>• Enclose, when appropriate, x-rays, tooth charting, periodontal charting<br>• Mail claims to : Self-Insured Dental Services, Dept. 31<br>P.O. Box 9005<br>Lynbrook, NY 11563<br>• 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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# Self-Insured Dental Services / Administrative Services Only, Inc. Dental Plan Administrators

| | PLAN PAYS |
|---|---|
| **I-DIAGNOSTIC** | |
| ORAL EXAM | 27.00 |
| PERIAPICAL X-RAY (1st & 2nd FILM) | 5.00 |
| PERIAPICAL X-RAY-each additional | 4.00 |
| OCCLUSAL FILM | 30.00 |
| FULL MOUTH X-RAY | 45.00 |
| BITEWING-(EACH FILM) | 5.00 |
| PANORAMIC FILM | 34.00 |
| PALLIATIVE TREATMENT | 20.00 |
| CONSULTATION | 35.00 |
| **II-PREVENTIVE** | |
| PROPHYLAXIS-ADULT | 50.00 |
| PROPHYLAXIS-CHILD(to age 13) | 35.00 |
| FLUORIDE EXCL. PROPHY | 15.00 |
| SEALANT | 15.00 |
| SPACE MAINTAINER | 91.00 |
| **III-RESTORATIVE** | |
| AMALGAM - 1 SRF PRIMARY | 25.00 |
| AMALGAM - 2 SRF PRIMARY | 35.00 |
| AMALGAM - 3 OR MORE SRF PRIMARY | 45.00 |
| AMALGAM - 1 SRF PERMANENT | 40.00 |
| AMALGAM - 2 SRF PERMANENT | 50.00 |
| AMALGAM - 3 SRF PERMANENT | 70.00 |
| AMALGAM - 4+ SRF PERMANENT | 80.00 |
| RESIN-1 SURFACE | 50.00 |
| RESIN-2+ SURFACE | 60.00 |
| RESIN-INCISAL ANGLE | 70.00 |
| METALLIC OR PORCELAIN INLAY-1 SRF | 200.00 |
| METALLIC OR PORCELAIN INLAY-2 SRF | 250.00 |
| METALLIC OR PORCELAIN INLAY-3 SRF | 375.00 |
| CROWN-PORCELAIN JACKET | 600.00 |
| CROWN-PORCELAIN WITH METAL | 650.00 |
| CROWN-RESIN TO METAL | 625.00 |
| CROWN FULL CAST | 550.00 |
| CROWN-3/4 CAST | 525.00 |
| RECEMENT INLAY | 25.00 |
| RECEMENT CROWN | 25.00 |
| PREFAB SS CROWN-PRIMARY | 85.00 |
| PIN RETENTION-PER TOOTH | 20.00 |
| CAST POST AND CORE | 125.00 |
| PREFAB POST AND CORE | 100.00 |
| **IV-ENDODONTICS** | |
| PULP CAP | 15.00 |
| VITAL PULPOTOMY | 40.00 |
| ROOT CANAL THERAPY-1 CANAL | 275.00 |
| ROOT CANAL THERAPY-2 CANALS | 350.00 |
| ROOT CANAL THERAPY-3 CANALS | 400.00 |
| ROOT CANAL THERAPY-4+ CANALS | 450.00 |
| APICOECTOMY-PER ROOT | 150.00 |

| **V-PERIODONTICS** | PLAN PAYS |
|---|---|
| GINGIVECTOMY-PER QUADRANT | 150.00 |
| OSSEOUS GRAFT-SINGLE SITE | 85.00 |
| OSSEOUS GRAFT-MULTIPLE SITE | 425.00 |
| FREE SOFT TISSUE GRAFT-PER QUAD | 300.00 |
| PEDICLE SOFT TISSUE GRAFT-PER QUAD | 300.00 |
| OSSEOUS SURGERY-PER QUAD | 400.00 |
| CURETTAGE, SCALE\ROOT PLANING-VISIT | 30.00 |
| CURETTAGE, SCALE\ROOT PLANING-FM | 60.00 |
| PERIODONTAL MAINTENANCE PROCEDURE | 65.00 |
| **VI-PROSTHODONTICS** | |
| DENTURE COMPLETE OR IMMEDIATE | 700.00 |
| PARTIAL DENTURE-ACRYLIC BASE WITH CLASPS AND RESTS | 525.00 |
| PARTIAL DENTURE-CAST BASE | 700.00 |
| UNILATERAL PARTIAL DENTURE | 350.00 |
| DENTURE ADJUSTMENT | 25.00 |
| REPLACE BROKEN FACING | 75.00 |
| REPLC MISS/BRKN TTH-COM DENT | 50.00 |
| REPAIR PART ACRYLIC SADDLE/BASE | 75.00 |
| REPAIR CAST FRAMEWORK | 90.00 |
| REPAIR OR REPLACE BROKEN CLASP | 65.00 |
| ADD TTH TO EXISTING PART DENT | 100.00 |
| ADD CLASP TO EXISTING PART DENT | 50.00 |
| RELINE DENTURE-CHAIR | 52.00 |
| RELINE COMPLETE DENTURE-LAB | 100.00 |
| RELINE PARTIAL DENTURE-LAB | 75.00 |
| TISSUE CONDITIONING | 30.00 |
| PONTIC-CAST METAL | 525.00 |
| PONTIC-PORCELAIN TO METAL | 625.00 |
| PONTIC-RESIN WITH METAL | 600.00 |
| CAST METL RETNR-ACID ETCH BRIDGE | 225.00 |
| CROWN-PORCELAIN WITH METAL | 650.00 |
| CROWN-FULL CAST OR 3/4 | 550.00 |
| RECEMENT BRIDGE | 35.00 |
| **VII-IMPLANTS** | |
| ENDOSSEOUS IMPLANT | 500.00** |
| CUSTOM ABUTMENTS | 200.00** |
| **VIII-ORAL SURGERY** | |
| SIMPLE EXTRACTION | 65.00 |
| SURGICAL EXTRACTION | |
| ERUPTED TOOTH | 75.00 |
| RETAINED ROOT | 85.00 |
| IMPACTION-SOFT TISSUE | 110.00 |
| IMPACTION-PARTIAL BONY | 175.00 |
| IMPACTION-COMPLETE BONY | 250.00 |
| EXPOSURE UNERUPTED/ORTHO | 125.00 |
| EXCISION OF HYPERPLASTIC TISSUE | 77.00 |
| REMOVAL OF EXOSTOSIS | 180.00 |
| BIOPSY OF SOFT TISSUE | 34.00 |
| BIOPSY OF HARD TISSUE | 42.00 |
| ALVEOPLASTY-PER JAW | 110.00 |
| CYST REMOVAL < 1.25CM | 70.00 |
| CYST REMOVAL > 1.25CM. | 100.00 |
| REMOVAL OF LABIAL FRENUM | 75.00 |

**1X-ORTHODONTICS**
**$** 1000 LIFETIME MAXIMUM

| **X-ADJUNTIVE SERVICES** | |
|---|---|
| GENERAL ANESTHESIA | 120.00 |
| BRUXISM APPLIANCE | 90.00 |

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****Not accepted as payment in full for in network providers**