CIVIL SERVICE BAR ASSOCIATION
METRODENT PREMIER PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE
Effective 11/1/2022

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

ELIGIBILITY	• Active attorneys employed by the City of New York and who are members of the Civil Service Bar Association. Part-time employees and their dependents are also eligible. • **Eligible dependents**: Include the lawful spouse and each dependent child from birth until the age of 26 is reached or have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
PLAN YEAR	• January 1 through December 31
PLAN MAXIMUM	• $2,500 per covered individual in a calendar year.
DEDUCTIBLE	• $50 per individual with a $100 family maximum, in a calendar year.
PLAN LIMITATIONS	• **Examination** – two in a calendar year • **Prophylaxis** – two in a calendar year • **X-rays** – $90 maximum per calendar year • **Replacement of crowns, bridges and dentures** – not more than once in 5 years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – to age 19, 1 application per year • **Sealant –** $15 on molars of children under age 19. • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $220 per calendar year • **Denture Adjustment –** one in a calendar year • **Orthodontic treatment –** maximum 24 months; limited to eligible dependent children and non-cosmetic adults. Orthodontic treatment is not subject to the $2,500 annual maximum. • **Implants –** three in a lifetime. • **Custom Abutment/Bone Graft-**Implant must be covered by Fund • **Specialist consultation –** includes allowance for examination, max two per calendar year. • **General Anesthesia** – maximum of 30 minutes per day
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 charges for deductibles, 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 or Signature Strips are not acceptable** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : ASO INC/ S.I.D.S. Dept 33. 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

Rev 11/22

CIVIL SERVICE BAR ASSOCIATION

SCHEDULE OF ALLOWANCES

I DIAGNIOSTIC	MAXIMUM CHARGE
ORAL EXAM	40.00
PERIODIC ORAL EXAM	30.00
PANORAMIC FILM or FULL MOUTH SERIES	55.00
P.A. OR B.W. EACH FILM	5.00
OCCLUSAL FILM	10.00
EXTRAORAL- (EACH FILM)	25.00
POSTERIOR-ANTERIOR, LATERAL FILM,TMJ FILM	20.00
SALIOGRAPHY	40.00
CEPHALOMETRIC FILM	40.00
PULP VITALITY TEST	15.00
DIAGNOSTIC CASTS	25.00
II-PREVENTIVE	
FLUORIDE TREATMENT	28.00
SEALANT	20.00
SPACE MAINTAINER	231.00
PROPHYLAXIS ADULT	55.00
PROPHYLAXIS CHILD	45.00
III-RESTORATIVE	
AMALGAM - 1 SURFACE	55.00
AMALGAM - 2 SURFACES	65.00
AMALGAM - 3 SURFACES	75.00
AMALGAM - 4 or more SURFACES	80.00
PIN RETENTION, per tooth	30.00
SEDATIVE FILLING	25.00
COMPOSITE RESIN - 1 SURFACE	60.00
COMPOSITE RESIN - 2 SURFACES	70.00
COMPOSITE RESIN - 3 or more SURFACES	85.00
COMPOSITE RESIN-INCISAL ANGLE	90.00
PORCELAIN INLAY - 1 SURFACE	275.00
PORCELAIN INLAY - 2 SURFACE	350.00
PORCELAIN INLAY - 3 SURFACE	375.00
METALLIC INLAY - 1 SURFACE	275.00
METALLIC INLAY - 2 SURFACES	350.00
METALLIC INLAY - 3 SURFACES	375.00
CROWN-STAINLESS STEEL, primary tooth	115.00
CROWN-PORCELIAN JACKET	425.00
CROWN-ACRYLIC JACKET-LAB	250.00
CROWN-PLASTIC WITH METAL	450.00
CROWN-PORCELAIN WITH METAL	500.00
CROWN-FULL CAST or 3/4 CAST	425.00
CROWN BUILDUP	75.00
CAST POST AND CORE	125.00
PREFABRICATED POST and CORE	100.00
LABIAL VENEER, LAB	250.00
RECEMENTATION-inlay, crown	50.00
V-ENDODONTICS	
PULP CAP-DIRECT	20.00
PULP CAP-INDIRECT	10.00
VITAL PULPOTOMY	80.00
ROOT CANAL THERAPY-Anterior	450.00
ROOT CANAL THERAPY-Bicuspid	500.00
ROOT CANAL THERAPY-Molar	700.00
RETREATMENT-ANTERIOR	550.00
RETEATMENT-BICUSPID	625.00
RETREATMENT-MOLAR	850.00
APICOECTOMY, per root	250.00
APICOECTOMY, maximum per tooth	500.00
RETROGRADE FILLING	100.00
HEMISECTION / ROOT AMPUTATION	150.00
VIII-ORTHODONTICS	
INITIAL APPLICANCE-INCL DIAGNOSIS	
ACTIVE TREATMENT-PER MONTH	
PASSIVE TREATMENT- PER 3 MONTHS	
POST TREATMENT STABILIZING DEVICE	

IV-PERIODONTICS	MAXIMUM	MEMBER CO-PAY
PERIODONTAL TREATMENT, per quad	55.00	
PERIODONTAL MAINTENANCE	110.00	
OSSEOUS SURGERY, including gingivectom	525.00	
OSSEOUS GRAFT-SINGLE SITE	90.00	
OSSEOUS GRAFT, per quad	250.00	
GINGIVECTOMY OR GINGIVOPLASTY	200.00	
OCCLUSAL ADJUSTMENT-COMPLETE	98.00	
OCCLUSAL ADJUSTMENT-LIMITED	51.00	
SOFT TISSUE GRAFT	325.00	
CHEMOTHERAPEUTIC AGENT- 5 per calen	35.00	
Max one per tooth per 24 months		
VI-PROSTHODONTICS		
COMPLETE and IMMEDIATE DENTURE	750.00	
PARTIAL DENTURE-CAST BASE	750.00	
PARTIAL DENTURE-ACRYLIC BASE	550.00	
UNILATERAL PARTIAL DENTURE	200.00	
DENTURE ADJUSTMENT	40.00	
REPAIR COMP DENT BASE	90.00	
REPAIR PART ACRYLIC SADDLE/BASE	90.00	
REPLC MISS/BRKN TTH-COM DENT	90.00	
REPAIR CAST FRAMEWORK	100.00	
REPAIR OR REPLACE CROWN FACING	100.00	
DENTURE RELINE, lab	175.00	
DENTURE RELINE, chair	100.00	
BRIDGE ABUTMENT		
CROWN-PLASTIC WITH METAL	375.00	
CROWN PORCELAIN FUSED TO METAL	475.00	
CROWN FULL CAST	450.00	
PRECISION ATTACHMENT	125.00	
BRIDGE PONTIC, porcelain with metal	475.00	
RECEMENTATION- bridge	75.00	
ENDOSSEOUS IMPLANT, per fixture	600.00	
SUBPERIOSTEAL IMPLANT	600.00	
CUSTOM/PREFAB ABUTMENT	250.00	250.00
ABUTMENT SUPP PORC/CER	500.00	200.00
ABUTMENT SUPP PORC/METL	500.00	200.00
ABUTMENT SUPP BASE METAL	500.00	100.00
IMPLANT SUPP PORC/METL	500.00	500.00
VII-ORAL SURGERY		
EXTRACTION OF CORONAL REM	60.00	
ROUTINE EXTRACTION	70.00	
SURGICAL EXTRACTION		
ERUPTED TOOTH	100.00	
IMPACTION-SOFT TISSUE	200.00	
IMPACTION-PARTIAL BONY	275.00	
IMPACTION-COMPLETE BONY	275.00	
SURGICAL EXPOSURE IMP/UNERUP	80.00	
SURGICAL EXPOSURE IMP/UNERUP-ORTH	160.00	
SURGICAL ROOT RECOVERY	100.00	
BIOPSY OF ORAL TISSUE	125.00	
REMOVAL OF CRST OR TUMOR		
CYST REMOVAL < 1.25CM	125.00	
CYST REMOVAL > 1.25CM	175.00	
ALVEOPLASTY-PER QUAD	125.00	
GENERAL ANESTHESIA-per 15 minutes	75.00	
FRENULECTOMY	150.00	
INCISION & DRAINAGE	50.00	
BONE GRAFT	150.00	150.00
IX-MISCELLANEOUS		
PALLIATIVE TREATMENT	40.00	
CONSULTATION BY SPECIALIST	50.00	
THERUPEUTIC DRUG INJECTION	19.00	
OCCLUSAL GUARD	0.00	200.00

REV 11/22