



Mailing Address:
381 Sunrise Hwy, Suite 307
Lynbrook, NY 11563

Toll Free: (800) 520 - 3368
Phone: (516) 887 - 7566
Fax: (516) 887 - 7896

Hauppauge Union Free School District Group 120

Summary of Benefits for Full-Time Member:

Dental:

- **Annual maximum \$1,500.00 individual, per calendar year**
- **Annual deductible \$50.00 individual on Basic and Major services only**
- **Family annual deductible \$150.00 on Basic and Major services only.**
- **Deductibles (if acquired last quarter of year, to be carried over previous year)**
- **Co-pay billable difference between schedules.**
- **Examination: No Frequency**
- **Prophylaxis: No Frequency**
- **Full Mouth or Panoramic X-Rays: No Frequency**
- **Fluoride: No Frequency**
- **Sealants: Covered up to age 16**
- **Major work: Five Year Limitation**
- **Missing tooth: Covered**

Orthodontia:

- **Adult Ortho (cut-off at age 65), maximum \$1,000.00, per individual**
- **Pays 50% for insertion and 50% for monthly**

Unicare – Out of New York/New Jersey

- **In Network fee minus**
- **Unicare fee is co-pay difference**

Pre-Authorizations:

- **Any claims over \$300.00 must be pre-authorized (In Network)**

- No pre-certs required
- Claim submission – 1 year
- Proof of Enrollments – Handled by Sele-Dent. (Ages – 19 thru 25, also covered 3 months after graduation from college
(If Wrap is paid then alright to pay dental claim)

In Network:

- Preventive paid at 100% of the Sele-Dent fee schedule
- All Basic and Major services are billed according to the Sele-Dent fee schedule
- The difference between the Sele-Dent fee schedule and the Hauppauge UFSD fee schedule balance is the co-pay-also \$50.00 dollar deductible and \$150.00 for Family.

Out of Network

- Preventive 100% of usual and customary, Basic and Major based on Hauppauge UFSD fee schedule, member pays balance of the bill.
- Also a \$50.00 dollar deductible and \$150.00 for Family

Hauppauge Union Free School District

ADA CODE	EXPLANATION OF CODE	MEMBER CO-PAYMENT
0140	PROBLEM FOCUS EXAM	\$23.00
2330	RESIN BASED COMP/ 1 SURFACE	\$0.80
2331	RESIN BASED COMP/ 2 SURFACE	\$8.00
2332	RESIN BASED COMP/ 3 SURFACE	\$30.40
2335	RESIN BASED COMP/ I SURFACE	\$36.80
2390	RESIN BASED COMP CROWN	\$10.80
2391	RESIN BASED COMP 1 SURFACE POST	\$11.70
2392	RESIN BASED COMP 2 SURFACE POST	\$9.00
2393	RESIN BASED COMP 3 SURFACE POST	\$20.00
2394	RESIN BASED COMP 4 SURFACE POST	\$56.80
2510	INLAY- METALLIC I SURFACE	\$60.60
2520	INLAY-METALLIC 2 SURFACE	\$3.20
2530	INLAY-METALLIC 3 SURFACE	\$32.00
2540	ONLAY METALLIC PER	\$29.60
2610	INLAY- PORCELAIN I SURFACE	\$18.40
2720	CROWN ACRYLIC W. GOLD	\$1.00
2740	CROWN PORCELAIN	\$12.20
2750	CROWN PORCELAIN/METAL	\$58.00
2752	CROWN PORCELAIN/ NOBEL METAL	\$67.50

2790	CROWN GOLD(FULL)	\$51.00
2810	CROWN GOLD ¾ CAST	\$1.60
2954	PREFABRICATED POST AND CORE	\$8.00
3110	PULP CAP DIRECT	\$.50
3426	APICOECTOMY/ ADD ROOT	\$137
4210	GINGIVAL PER QUADRANT	\$43.00
4220	GINGIVAL CURETTAGE	\$9.00
4260	OSSEOUS SURGERY QUADRANT	\$29.00
4261	OSSEOUS SURGERY QUADRANT #1-3	\$14.05
4321	PROV SPLINTING EXTERIOR	\$51.00
4910	PERIO PROPHYLAXIS	\$6.00
5130	DENTURES IMM UPPER	\$2.00
5410	ADJ. COMPLETE DENTURE UPPER	\$45.00
5411	ADJ. COMPLETE DENTURE LOWER	\$18.00
5421	PARTIAL DENTURE UPPER	\$23.60
5730	RELINING COMPLETE UPPER	\$13.00
5731	RELINING COMPLETE LOWER	\$13.00
5741	DENT RELINING COMPLETE LOWER	\$10.80
6240	BRIDGE PORCELAIN /METAL	\$7.40
6250	BRIDGE PLASTIC/METAL	\$60.20
6253	PROVISIONAL PONTIC	\$65.00
6520	GOLD INLAY 2 SURFACE	\$25.60
6530	GOLD INLAY 3 OR MORE SURFACE	\$43.20
6540	GOLD INLAY	\$9.20
6720	CROWN PLASTIC NON PRECIOUS MET	\$35.40
6750	CROWN PORCELAIN NON PRECIOUS M	\$50.00
6790	PROVISIONAL RETAINER CROWN	\$45.40
6930	STRESS BREAKER	\$1.80
7110	EXTRACT SINGLE	\$11.00
7111	DECIDUOUS TOOTH EXTRACTION	\$11.00
7120	EXTRACT ADDITIONAL	\$13.40
7140	ERUPT TOOTH EXPOSED ROOT EXT	\$31.40
7220	EXTRACT IMPACT TOOTH	\$52.40
7230	EXTRACT IMPACT PART	\$68.00
7240	EXTRACT IMPACT FULL	\$105.00
7241	REMOVAL OF IMPACTED TOOTH	\$85.00
7250	TOOTH RECOVERY	\$25.00
7281	EXPOSE IMPACT COMPL	\$95.00
7285	BIOPSY HARD TISSUE	\$15.00
7310	ALVEOL W/EXTRACT	\$38.80
7320	ALVEOL NON EXTRACT	\$77.40

7420	RADICAL EXCISION >5"	\$14.00
7431	EXC BEN TUMOR >5"	\$54.00
7450	ODO CYST <5"	\$43.40
7451	ODO CYST >5"	\$36.00
7460	NON ODO CYST <5"	\$12.00
7461	NON ODO CYST >5"	\$98.00
7510	RAD INCIS INTRA ORAL	\$36.20
7520	RAD INCIS EXTRA ORAL	\$117.00
7970	ALVEOLUS, RED SPLINT	\$137.00
9110	PALLIATIVE TREATMENT	\$1.20
9210	LOCAL ANESTHESIA	\$6.20
9212	TRIG DIV BLK ANES	\$10.00
9220	GENERAL ANESTHESIA	\$36.60
9221	GEN ANES/ EACH ADD 15	\$55.80
9230	ANALGESIA	\$62.20
9241	IV SEDATION / ANALGESIA	\$36.60
9242	IV SEDATION – EACH ADD	\$36.60
9310	CONSULTATION	\$48.00
9940	OCCLUSAL GUARD	\$50.00
9950	OCCLUSION ANALYSIS	\$50.00
9951	OCCLUSAL ADJUST	\$12.00
9952	OCCLUSAL ADJUST COM	\$39.00

PROCEDURES NOT COVERED UNDER THE PLAN MEMBER PAYS 100% OF THE SELEDENT FEES