UCE of FIT
PLAN DESCRIPTION & FEE SCHEDULE

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

ELIGIBILITY	• Full time staff, faculty and college administrators currently employed by the Fashion Institute of Technology and covered members of the UCE of FIT Welfare Trust Fund. • **Eligible dependents**: Include the lawful spouse and each dependent child from birth until the end of the Month in which they turn age 26 so long as they are not covered by or eligible for other health insurance through their employer and have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
PLAN YEAR	• January 1 st through December 31 st
PLAN MAXIMUM	• Active Members: $3,000 per individual in a calendar year • Retired Members: $3,000 per individual and $6,000 per Member & Spouse Only • Part-time Employees: $3,000 per family in a calendar year
DEDUCTIBLE	• $50 per individual, per calendar year. **Waived on preventive and diagnostic services.**
PLAN LIMITATIONS	• **Examination** – three in a calendar year • **Prophylaxis** – three in a calendar year • **Prophylaxis Child** – to age 13, two in a calendar year • **X-rays** – full mouth series or panorex 1 per 36 months; bitewings-4 per six months; periapicals-5 per six months • **Palliative treatment** – no other treatment rendered that same visit • **Periodontal treatment/Maintenance –** 4 visits in a calendar year, $252 maximum in a calendar year • **Replacement of Prosthetics –** once in 5 years • **Implant Services –** Implants are not reimbursable by the fund. Participating providers are asked to accept the fee of $1,200 for the placement of the implant, payable by the member. • **Orthodontic treatment –** Lifetime maximum benefit $2,220, maximum 24 months active treatment, per covered individual
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 and established co-payment • **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 from 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 is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to : Self-Insured Dental Services, Dept V13. 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 (800) 537-1238

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UCE OF FIT WELFARE FUND
SCHEDULE OF ALLOWANCES

DIAGNOSTIC & PREVENTIVE	**PLAN ALLOWANCE**
ORAL EXAM	40.00
FULL MOUTH SERIES	70.00
PANORAMIC X-RAY	48.00
PERIAPICAL X-RAY, FIRST FILM	10.00
BITEWING X-RAY, FIRST FILM	7.00
OCCLUSAL FILM	18.00
EXTRAORAL FILM, TMJ VIEW	36.00
EXTRAORAL FILM, AP/LATERAL	30.00
PROPHYLAXIS - ADULT	50.00
PROPHYLAXIS - CHILD	42.00
SEALANT	18.00
SPACE MAINTAINER	150.00
RESTORATIVE	
PERMANENT SILVER AMALGAM FILLINGS	
one surface	45.00
two surface	48.00
three or more surfaces	60.00
COMPOSITE, ANTERIOR	60.00
BONDED RESIN, INCISAL ANGLE	80.00
PIN RETENTION	25.00
METALLIC OR PORCELAIN INLAY/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
PORCELAIN Laminate Veneer	258.00
CROWNS AND BRIDGES	
CROWNS	
acrylic jacket (lab processed)	180.00*
stainless steel (primary tooth)	100.00
porcelain jacket	300.00*
porcelain with metal	400.00*
full cast, metal	300.00*
3/4 cast, metal	300.00*
maryland bridge retainer	180.00
BRIDGE PONTICS	
full cast	330.00*
plastic with metal	330.00*
porcelain with metal	330.00*
RECEMENTATION	
of crown or inlay	30.00
bridge	40.00
REPLACE FACING	100.00
PERIODONTICS	
PERIODONTAL TREATMENT	
root scaling, subgingival curettage, bite correct,per quad	50.00
including prophy per visit	100.00
PERIODONTAL MAINTENANCE PROCEDURE	60.00
GINGIVAL SURGERY	
based on 5 teeth per quad	
gingivectomy or gingivoplasty, soft tissue graft, vestibuloplasty, any combination	132.00
OSSEOUS SURGERY	360.00*
OSSEOUS GRAFT, per site, max of 2 sites per quad	132.00

ORAL SURGERY	**MAXIMUM CHARGE**
ROUTINE EXTRACTION	54.00
SURGICAL EXTRACTION	
must be demonstrated by pre-op xray	
erupted tooth	110.00
retained root	90.00
impaction-soft tissue	115.00
impaction-partial bony	185.00
impaction-complete bony	225.00
SURGICAL EXPOSURE OF IMPACTED	
OR UNERUPTED TOOTH-for Ortho	108.00
to aid eruption	160.00
CYST REMOVAL	125.00
CLOSURE OF ORAL ANTRAL FISTULA	78.00
ALVEOLOPLASTY-per quad	78.00
FRENULECTOMY	95.00
BIOPSY	75.00
ENDOSTEAL IMPLANT**	
***direct reimbursement from member	***1200.00***
DENTURES	
COMPLETE DENTURE	
immediate or permanent	600.00*
PARTIAL DENTURE, Bilateral acrylic base	375.00*
PARTIAL DENTURE, Bilateral cast base	550.00*
PARTIAL DENTURE, Unilateral	210.00
OBTURATOR	78.00
DENTURE REPAIRS	
broken denture base	90.00
repair acrylic saddle or base	90.00
replace tooth in denture	85.00
add or replace clasp	85.00
add tooth to existing partial	78.00
DENTURE RELINE	
complete denture - office	75.00
partial denture - office	75.00
complete denture - lab	125.00
partial denture - lab	102.00
ENDODONTICS	
PULP CAP	12.00
VITAL PULPOTOMY	42.00
ROOT THERAPY	
one canal	275.00*
two canals	290.00*
three canals	458.00*
APICOECTOMY, FIRST ROOT	150.00
APICOECTOMY, MAX PER TOOTH	300.00
RETROGRADE ROOT FILLING	85.00
ROOT RESECTION/HEMISECTION	120.00
ORTHODONTICS	
DIAGNOSIS AND INITIAL APPLIANCE	
full treatment-fixed appliance	516.00*
ACTIVE TREATMENT-per month	60.00
PASSIVE TREATMENT-per 3 months	60.00
RETAINER	120.00
ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT no other trtmt that visit	18.00
GENERAL ANESTHESIA / IV SED-1st 30 min only	90.00*
GENERAL ANESTHESIA-additional	42.00
BRUXISM APPLIANCE	120.00

*** Services include $50 co-payment**

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