UFT WELFARE FUND

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

Eligibility	* Members who meet eligibility requirements according of the Plan * **Eligible dependents:** Include the lawful spouse/partner and each dependent child from birth until the age of 26 is reached as long as they are not covered by or eligible for other health insurance through their employer. Full time students are covered to age 29.
Plan Year	* October-September
Plan Maximums	* **Personal Maximum:** No Maximum * **Family Max Maximum:** No Maximum
Plan Deductibles	* No Deductible
Plan Limitations	* **Exam Limitations** 1 per 6 months * **Diagnostic And Preventative Fms/Panorex Limit** 1 per 36 Months * **Bitewing Film** 1 per 6 Months * **Prophy Limitations** 1 per 3 months * **Adult Ortho** $1890 per Lifetime. / $1,005 Member Copay * **Child Ortho** $1890 per Lifetime. / $1,005 Member Copay * **Number Of Months On Prosthetic Limit** 1 per 60 Months * **Dependents Covered To Age** 26 * **Student Dependents Covered To Age** 29 * **Replacement Of Fillings** 1 per 24 Months * **Grafts Per Quad** 2 per 36 Months. / Maximum 2 Grafts Or Gtrs Per Quad * **1 Curretage Per Visit** 2 per Day * **Sealants** 1 per Lifetime. / Unrestored Permanent Molars To Age 16 * **Scaling & Root Planing** 1 per 24 Months
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 pretreatment 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
Permissable Charges	* **Covered and reimbursable services, no co-payment:** No surcharge permitted * **Covered and reimbursable services, with co-payment:** Established co-payment only * **Covered but not reimbursable services:** Schedule allowance plus established co-pay * **Non Covered services:** Your usual charge for that service * If you and your patient decide on a more costly treatment option than the one provided by the plan (e.g. upgraded materials, posterior composite fillings, special esthetic restorations), the Plan payment will be based on the less costly service, you must get a signed release from the patient prior to treatment. The patient will then be responsible for the difference between the Plan payment and the disclosed Office Fee. * If an orthodontic case requires more than 24 months of treatment, the patient is responsible for the additional months of active orthodontic treatment.
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 or other charges incurred by the member.Internal coordination of benefits for Participating Dentists is limited to designated member co-payments.
How to File a Claim	* **Electronic Claims (Payor ID:** 62308): To submit through your Practice Managament Software and Clearinghouse use Payor ID: 62308. * **Paper Claims:** Computer generated, ADA, and universal claim forms are accepted. . You may use your office software or clearinghouse to upload x-rays and attachments. . Mail claims to CIGNA PO Box 182531 , Chattanooga , TN 37422-7531

For up to date detailed information, including member eligibility and claim status, please visit:
cignaforhcp.com or call CIGNA at 800-577-0576
If you have any questions regarding the this program please call us:
516-394-9408

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Plan Schedule (In and Out of Network)

Code	Description	Maximum Charge	Plan Payment	In-Network CoPayment
D0120	Periodic Oral Examination 1 per 6 months	$45.00	$30.00	$15.00
D0140	Limited Oral Evaluation 1 per 6 months	$45.00	$30.00	$15.00
D0150	Comprehensive Oral Examination 1 per 6 months	$45.00	$30.00	$15.00
D0210	X-Rays-Full Mouth 1 per 36 Months	$50.00	$50.00	$0.00
D0220	Periapical X-Ray First Film 5 per 6 months	$6.00	$6.00	$0.00
D0230	X-Ray Periapical -Additional 4 per 6 months	$6.00	$6.00	$0.00
D0240	Occlusal Film	$15.00	$15.00	$0.00
D0250	Xray-Extraoral	$15.00	$15.00	$0.00
D0260	Extraoral-Each Additional	$15.00	$15.00	$0.00
D0270	X-Ray 1 Bitewing 4 per 6 Months	$6.00	$6.00	$0.00
D0272	X-Rays 2 Bitewings 2 per 6 Months	$12.00	$12.00	$0.00
D0273	X-Rays 3 Bitewings 1 per 6 Months	$18.00	$18.00	$0.00
D0274	X-Rays 4 Bitewings 1 per 6 Months	$24.00	$24.00	$0.00
D0290	X-Ray Ant. Post. Or Lateral	$25.00	$25.00	$0.00
D0321	Tmj Film 1 per 12 Months	$30.00	$30.00	$0.00
D0330	Panoramic Film 1 per 36 Months	$50.00	$50.00	$0.00
D1110	Prophylaxis 1 per 3 months	$45.00	$45.00	$0.00
D1120	Prophylaxis-Child 1 per 6 months	$45.00	$45.00	$0.00
D1351	Sealant 1 per Lifetime Covered Until Age 16	$30.00	$30.00	$0.00
D1355	Caries Preventive Medicament App- Per Tooth	$48.00	$48.00	$0.00
D1510	Space Maintainer-Fixed	$300.00	$100.00	$200.00
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	$200.00	$200.00	$0.00
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	$300.00	$100.00	$200.00
D2140	Amalgam One Surface -Permanent Or Primary 1 per 24 Months	$55.00	$40.00	$15.00
D2150	Amalgam Two Surfaces-Permanent Or Primary 1 per 24 Months	$65.00	$50.00	$15.00
D2160	Amalgam Three Surfaces-Perm Or Prime 1 per 24 Months	$75.00	$60.00	$15.00
D2161	Amalgam-Four Or More Surfaces Perm Or Prim 1 per 24 Months	$75.00	$60.00	$15.00
D2330	Resin - One Surface 1 per 24 Months	$70.00	$55.00	$15.00
D2331	Resin - Two Surfaces 1 per 24 Months	$70.00	$55.00	$15.00
D2332	Resin Three Or More Surfaces 1 per 24 Months	$70.00	$55.00	$15.00
D2335	Resin-4+ Srf Or Incisal Edge 1 per 24 Months	$85.00	$70.00	$15.00
D2391	Resin 1 Surface Posterior 1 per 24 Months	Balance to Office Fee*	$40.00	Balance to Office Fee*
D2392	Resin-2 Surfaces,Posterior 1 per 24 Months	Balance to Office Fee*	$50.00	Balance to Office Fee*
D2393	Resin-3 Surfaces,Post. 1 per 24 Months	Balance to Office Fee*	$60.00	Balance to Office Fee*
D2394	Resin-4 Or More Srf-Post 1 per 24 Months	Balance to Office Fee*	$60.00	Balance to Office Fee*
D2510	Inlay-Metallic -One Surface 1 per 60 months	$150.00	$150.00	$0.00
D2520	Inlay Metallic -Two Surfaces 1 per 60 months	$175.00	$175.00	$0.00
D2530	Inlay-Metallic-Three Or More S 1 per 60 months	$200.00	$200.00	$0.00

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Plan Schedule (In and Out of Network)

Code	Description	Maximum Charge	Plan Payment	In-Network CoPayment
D2610	Inlay-Porcelain 1 Surface 1 per 60 Months	Balance to Office Fee*	$150.00	Balance to Office Fee*
D2620	Inlay-Porcelain 2 Surfaces 1 per 60 Months	Balance to Office Fee*	$175.00	Balance to Office Fee*
D2630	Inlay-Porcelain-3 Or More Surf 1 per 60 Months	Balance to Office Fee*	$200.00	Balance to Office Fee*
D2650	Inlay-Composite-One Surface	Balance to Office Fee*	$150.00	Balance to Office Fee*
D2651	Inlay Composite 2 Srf	Balance to Office Fee*	$175.00	Balance to Office Fee*
D2652	Inlay Composite 3 Srf	Balance to Office Fee*	$200.00	Balance to Office Fee*
D2710	Crown-Resin (Laboratory) 1 per 60 months	$250.00	$100.00	$150.00
D2720	Crown Resin With Metal 1 per 60 Months	Balance to Office Fee*	$220.00	Balance to Office Fee*
D2721	Crown-Resin With Base Metal 1 per 60 months	$370.00	$220.00	$150.00
D2722	Crown-Resin With Noble Metal 1 per 60 Months	Balance to Office Fee*	$220.00	Balance to Office Fee*
D2740	Crown – Porcelain/Ceramic Substrate 1 per 60 months ANTERIOR TEETH ONLY	$425.00	$275.00	$150.00
D2750	Crown-Porc.Fused To Metal 1 per 60 months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D2751	Crown-Porc.Fused To Base Metal 1 per 60 months	$475.00	$325.00	$150.00
D2752	Crown-Porc.Fused To Noble Meta 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D2781	Crown-3/4 Cast Base Metal 1 per 60 months	$325.00	$175.00	$150.00
D2790	Crown-Full Cast Metal 1 per 60 Months	Balance to Office Fee*	$200.00	Balance to Office Fee*
D2791	Crown-Full Cast Base Metal 1 per 60 months	$350.00	$200.00	$150.00
D2792	Crown-Full Cast Noble Metal 1 per 60 Months	Balance to Office Fee*	$200.00	Balance to Office Fee*
D2794	Crown-Titanium 1 per 60 Months	Balance to Office Fee*	$200.00	Balance to Office Fee*
D2910	Recement Inlay	$15.00	$15.00	$0.00
D2920	Recement Crown	$15.00	$15.00	$0.00
D2930	Prefabricated Ss Crown-Primary	$150.00	$150.00	$0.00
D2951	Pin Support Per Tooth	$12.00	$12.00	$0.00
D2952	Cast Post & Core 1 per 60 months	$125.00	$125.00	$0.00
D2954	Prefab Post & Core 1 per 60 months	$60.00	$60.00	$0.00
D2960	Labial Laminate 1 per 60 months	$215.00	$215.00	$0.00
D2961	Resin Laminate-Laboratory 1 per 60 Months	Balance to Office Fee*	$215.00	Balance to Office Fee*
D2962	Porcelain Laminate 1 per 60 Months	Balance to Office Fee*	$215.00	Balance to Office Fee*
D2980	Repair Broken Crown Facing	$50.00	$50.00	$0.00
D3110	Pulp Cap-Direct	$10.00	$10.00	$0.00
D3220	Vital Pulpotomy	$35.00	$35.00	$0.00
D3310	Root Canal Therapy-Anterior Tooth 1 per Lifetime	$350.00	$200.00	$150.00
D3320	Root Canal Therapy-Bicuspid Tooth 1 per Lifetime	$425.00	$275.00	$150.00
D3330	Root Canal Therapy-Molar Tooth 1 per Lifetime	$600.00	$450.00	$150.00
D3346	Retreatment-Rct -Anterior 1 per Lifetime	$550.00	$125.00	$425.00
D3347	Retreatment Of Rct - Bicuspid 1 per Lifetime	$700.00	$200.00	$500.00
D3348	Retreatment Rct-Molar 1 per Lifetime	$1,050.00	$375.00	$675.00
D3410	Apicoectomy-First Root	$275.00	$275.00	$0.00

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Code	Description	Maximum Charge	Plan Payment	In-Network CoPayment
	1 per Lifetime			
D3421	Apico.-Premolar-First Root 1 per Lifetime	$275.00	$275.00	$0.00
D3425	Apico.-Molar-First Root 1 per Lifetime	$275.00	$275.00	$0.00
D3426	Apicoectomy-Each Additional Rt 1 per Lifetime MAXIMUM ONE PER TOOTH	$150.00	$150.00	$0.00
D3428	Bone Graft In Conjunction With Peri Surgery	$110.00	$110.00	$0.00
D3429	Bone Graft In Conjunction With Periradicular Surge	$110.00	$110.00	$0.00
D3430	Retrograde Filling	$100.00	$100.00	$0.00
D3450	Root Resection	$200.00	$200.00	$0.00
D3920	Hemisection	$100.00	$100.00	$0.00
D4210	Gingivectomy Or Gingivoplasty 1 per 36 months	$110.00	$110.00	$0.00
D4211	Gingivectomy One To Three Teeth-Per Quad 1 per 36 months	$55.00	$55.00	$0.00
D4249	Crown Lengthening PER SITE	$225.00	$0.00	$225.00
D4260	Osseous Surgery-Per Quadrant Must have history of Root Planning and Scaling	$525.00	$475.00	$50.00
D4261	Osseous Surgery 1 -3 Teeth Must have history of Root Planning and Scaling	$345.00	$295.00	$50.00
D4263	Osseous Graft- Per Site 1 per 36 months MAXIMUM 2 GRAFT OR GTR PER QUAD	$275.00	$175.00	$100.00
D4264	Osseous Graft-Addtional 1 per 36 months	$125.00	$125.00	$0.00
D4266	Guided Tissue Regen-Resorb 1 per 36 months MAXIMUM 2 GRAFT OR GTR PER QUAD	$225.00	$225.00	$0.00
D4267	Guided Tissue Regen-Nonresorb MAXIMUM 2 GRAFT OR GTR PER QUAD	$275.00	$275.00	$0.00
D4341	Perio Treatment Per Quad 1 per 24 Months MAXIMUM 2 QUADRANTS PER DAY	$50.00	$50.00	$0.00
D4342	Scaling-Root Planing 1 To 3 Teeth 1 per 24 Months MAXIMUM 2 QUADRANTS PER DAY	$45.00	$45.00	$0.00
D4910	Periodontal Maintenance 4 per 1 years Must have history of Osseous Surgery	$70.00	$70.00	$0.00
D5110	Complete Upper Denture 1 per 60 months	$475.00	$325.00	$150.00
D5120	Complete Lower Denture 1 per 60 months	$475.00	$325.00	$150.00
D5130	Immediate Full Upper Denture 1 per Lifetime	$475.00	$325.00	$150.00
D5140	Immediate Full Lower Denture 1 per Lifetime	$475.00	$325.00	$150.00
D5211	Upper Partial-Acrylic Base W/C 1 per 60 months	$375.00	$225.00	$150.00
D5212	Lower Partial Acrylic W/Clasps 1 per 60 months	$375.00	$225.00	$150.00
D5213	Upper Partial - Cast Metal 1 per 60 months	$475.00	$325.00	$150.00
D5214	Lower Partial - Cast Metal 1 per 60 months	$475.00	$325.00	$150.00
D5282	Removable Unilateral Partial Denture Maxiillary 1 per 60 months	$275.00	$125.00	$150.00
D5283	Removable Unilateral Partial Denture-Mandibular 1 per 60 months	$275.00	$125.00	$150.00
D5511	Repair Broken Complete Denture Base, Mandibular	$90.00	$90.00	$0.00
D5512	Repair Broken Complete Denture Base, Maxillary	$90.00	$90.00	$0.00
D5520	Replace Broken Tth In Denture	$35.00	$35.00	$0.00
D5630	Repair Or Replace Broken Clasp	$63.00	$63.00	$0.00
D5640	Replace Broken Tooth	$65.00	$65.00	$0.00
D5650	Add Tooth To Denture	$90.00	$90.00	$0.00
D5710	Rebase Full Upper	$165.00	$165.00	$0.00

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Plan Schedule (In and Out of Network)

Code	Description	Maximum Charge	Plan Payment	In-Network CoPayment
	1 per 36 months			
D5711	Rebase Full Lower 1 per 36 months	$165.00	$165.00	$0.00
D5730	Reline Complete Maxillary Denture (Chairside) 1 per 36 months	$85.00	$85.00	$0.00
D5731	Reline Complete Mandibular Denture (Chairside) 1 per 36 months	$85.00	$85.00	$0.00
D5740	Reline Maxillary Partial Denture (Chairside)	$85.00	$85.00	$0.00
D5741	Reline Mandibular Partial Denture (Chairside)	$85.00	$85.00	$0.00
D5750	Reline Upper Denture-Lab	$165.00	$165.00	$0.00
D5751	Reline Comp Lower Denture-Lab	$165.00	$165.00	$0.00
D5760	Reline Partial Upper-Lab	$165.00	$165.00	$0.00
D5761	Reline Partial Lower-Lab.	$165.00	$165.00	$0.00
D6010	Endosteal Implant	$1,200.00	$0.00	$1200.00
D6059	Abutment Supported Porc/Met Cr 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6065	Implant Supported Porc/Cer Cr 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6066	Implant Sup Porc/High Nobel 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6067	Implant Supp High Noble Metl 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6075	Impl Supp Retain For Ceram Fpd 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6076	Impl Supp Retain For Porc Fpd 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6194	Abutment Supported Retainer Crown For Fpd 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6210	Pontic Cast Gold 1 per 60 Months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6211	Pontic-Full Cast 1 per 60 Months	$150.00	$150.00	$0.00
D6212	Pontic-Full Cast Noble Metal 1 per 60 Months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6240	Pontic Porc Fused To Metal 1 per 60 months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6241	Pontic-Porc.Fused To Base Meta 1 per 60 months	$375.00	$225.00	$150.00
D6242	Pontic-Porc.Fused To Noble Met 1 per 60 months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6250	Pontic Resin With Metal 1 per 60 Months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6251	Pontic-Resin With Base Metal 1 per 60 Months	$375.00	$225.00	$150.00
D6252	Pontic-Resin With Noble Metal 1 per 60 Months	Balance to Office Fee*	$225.00	Balance to Office Fee*
D6545	Maryland Bridge Retainer 1 per 60 months	$150.00	$150.00	$0.00
D6750	Abutment-Porc. Fused To Metal 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6752	Abutment-Porc.Fused To Noble M 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6790	Abutment Full Cast Metal 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6791	Abutment-Full Cast Base Metal	$350.00	$200.00	$150.00
D6792	Abutment-Full Cast Noble Metal 1 per 60 Months	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6794	Crown-Titanium	Balance to Office Fee*	$325.00	Balance to Office Fee*
D6930	Recement Bridge	$15.00	$15.00	$0.00
D6980	Fixed Partial Denture Repair Necessitated By Resto	$50.00	$50.00	$0.00
D7140	Extraction Erupted Tooth Or Exposed Root	$55.00	$40.00	$15.00
D7210	Surgical Extraction	$150.00	$100.00	$50.00
D7220	Removal-Soft Tissue Impacted	$175.00	$175.00	$0.00
D7230	Removal-Partial Bony Impacted	$225.00	$225.00	$0.00
D7240	Removal-Complete Bony Impacted	$300.00	$300.00	$0.00
D7241	Complete Bony Impact-W/Comp	Balance to Office Fee*	$300.00	Balance to Office Fee*

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Plan Schedule (In and Out of Network)

Code	Description	Maximum Charge	Plan Payment	In-Network CoPayment
D7250	Removal Of Residual Roots	$120.00	$120.00	$0.00
D7260	Closure Of Oral Antral Fistula	$450.00	$200.00	$250.00
D7280	Surg.Exp-Imp/Unerup(For Ortho)	$250.00	$250.00	$0.00
D7285	Biopsy Hard Tissue	$150.00	$150.00	$0.00
D7286	Biopsy Soft Tissue	$55.00	$55.00	$0.00
D7310	Alveolectomy	$65.00	$65.00	$0.00
D7311	Alveoloplasty W/Ext Per Qd-1 To 3 Teeth	$90.00	$90.00	$0.00
D7320	Alveolectomy-Per Quad.-No Ext	$150.00	$150.00	$0.00
D7321	Alveolectomy No Ext--1 To 3 Teeth	$90.00	$90.00	$0.00
D7450	Cyst/Tumor Removal < 1.25 Cm	$150.00	$150.00	$0.00
D7451	Cyst Or Tumor Rem- > 1.25 Cm	$200.00	$200.00	$0.00
D7961	Buccal/Labial Frenectomy (Frenulectomy)	$200.00	$200.00	$0.00
D7962	Lingual Frenectomy (Frenulectomy)	$200.00	$200.00	$0.00
D8080	Initial Ortho App-Adolescent 1 per Lifetime	$675.00	$475.00	$200.00
D8090	Initial Ortho App-Adult 1 per Lifetime	$675.00	$475.00	$200.00
D8670	Active Ortho Treat Per Month 24 per Lifetime	$60.00	$45.00	$15.00
D8680	Ortho Retention (Remov App, Constr/Place Retainer) 1 per Lifetime	$300.00	$100.00	$200.00
D8681	Removable Orthodontic Retainer Adjustment 3 per Lifetime	$60.00	$45.00	$15.00
D9110	Palliative Treatment	$30.00	$30.00	$0.00
D9222	Deep Sedation/General Anesthesia – First 15 Minute	$85.00	$35.00	$50.00
D9223	Deep Sedation/General Anesthesia - Each 15 Minute	$85.00	$35.00	$50.00
D9230	Analgesia	$50.00	$50.00	$0.00
D9242	Intravenous Conscious Sedation-Each 15 Min	$85.00	$35.00	$50.00
D9243	Intravenous Moderate (Conscious)-15 Min	$85.00	$35.00	$50.00
D9248	Non-Iv Concious Sedation	$35.00	$35.00	$0.00
D9310	Specialist Consultation	$75.00	$0.00	$75.00
D9944	Occlusal Guard – Hard Appliance, Full Arch	$300.00	$100.00	$200.00
D9951	Occlusal Adjustment-Limited	$35.00	$35.00	$0.00

*** If you and your patient decide on a more costly treatment option than the one provided by the plan (e.g. upgraded materials, posterior composite fillings, special esthetic restorations), the Plan payment will be based on the less costly service, you must get a signed release from the patient prior to treatment. The patient will then be responsible for the difference between the Plan payment and the disclosed Office Fee.**

We request that the office provide the best discounted Office Fee to UFT patients. Offices discounting their fee should email providerrelations@uftdental.com or call 516-394-9494 to have their profile noted and increase their listings' visibility.