UCE of FIT Welfare Trust Fund

For Full-Time Employees
& Dependents,
For Retirees & Dependents
and
For Eligible Part-Time Employees
& Dependents

Dental Schedule

MARCH 2013

ELIGIBLE:

- Full-time staff, faculty and auxiliary staff currently employed by or at the Fashion Institute of Technology.
- Retirees who meet pre-defined pension, age and service requirements.
- Actively employed part-time employees upon attainment of a C.C.E.
- Dependents of full time and C.C.E employees and retirees are covered through the end of the month in which they reach age 26 provided 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 MAXIMUM:

Full-time Employees-$3,000 per individual in a calendar year.
Retirees-$3,000 per individual, $6,000 per family in a calendar year
Part-time Employees-$3,000 per family in a calendar year

ORTHODONTICS: There is a maximum of 24 months of active treatment and 9 months of passive treatment. Benefits for Orthodontic treatment are included in the annual maximum.

ANNUAL DEDUCTIBLE: Effective January 1, 2013, there is a $50 deductible per covered individual. The annual deductible is waived for diagnostic and preventive services.

COVERED EXPENSES: Covered Expenses include charges incurred for the performance of Dental Services provided for in the **UCE of FIT WELFARE TRUST FUND Dental Schedule**, when the Dental Service is performed by or under the direction of a duly licensed Dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- for a crown, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

HOW TO FILE A CLAIM: After dental work is performed, have your Dentist complete all items in the Dentist Information portion of the Claim Form and list the procedures, dates of services and charges and sign in the space provided for Dentist signature. You should then complete all items in the Member Information portion. Be sure to include spouse and dependent information.

Completed claim forms, with x-rays and other attachments, should be sent to:

S.I.D.S. / A.S.O., Dept.13
PO Box 9005
Lynbrook, NY 11563
516-396-5500/718-204-7172

Claim Forms are available from the Fund office. Dental claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed. If you would like the payment made directly to your Dentist, you may do so by signing the "Authorization to Assign Benefits" box on the claim form. Reimbursement will be at the rate of 100% of the fees listed in the **Schedule of Covered Dental Expenses**, not to exceed actual Dentists charges.

EXTENSION OF BENEFITS: An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, fixed bridgework and full or partial dentures, a Pre-treatment Review Estimate was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after that person's eligibility terminated.
- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not shown above.

PRE-TREATMENT REVIEW: This process is intended to inform you and your dentist, in advance of treatment, what benefits are provided by the Dental Program. It enables you to obtain full knowledge of the operation of your dental plan prior to undertaking treatment and incurring expenses.

A Claim Form for Pre-treatment Review Estimate should be filed by your Dentist if the course of treatment prescribed for you is expected to cost more than $500 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery. The Dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary x-rays and other supporting documentation to:

S.I.D.S. / A.S.O., Dept.13
P.O. Box 9005
Lynbrook, NY 11563
www.asonet.com

S.I.D.S. / A.S.O. will review the proposed treatment and apply the appropriate Plan provisions. You and your Dentist will receive a report showing the exact amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your Dentist.

If you receive a Pre-treatment Review Estimate for a proposed course of treatment that was submitted by one Dentist, that Pre-Treatment Review Estimate will remain valid if you elect to have some or all of the work done by another Dentist. The Pre-Treatment Review Estimate will be honored for one year after issuance.

Please be aware that a Pre-treatment Review Estimate is not a promise of payment. Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits) and no significant change occurred in the condition of your mouth after the Pre-Treatment Review Estimate was issued. Payment will be made in accordance with plan allowances and limitations in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION: Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive Alternate Course of Treatment. This should in no way be considered a reflection on your treating dentist's recommendations. By using the Pre-Treatment Review Estimate procedures you and your Dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a Pre-Treatment Review Estimate, the benefits paid by the Dental Plan may be based on the less expensive treatment.

COORDINATION OF DENTAL BENEFIT: If you or your family members are eligible to receive dental benefits under another group plan in addition to the UCE of FIT Welfare Fund Dental Plan, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. The allowable expense for a procedure is defined as the average usual and customary charge for a specific geographic area. You may not, however, receive benefits under this plan as both an employee and a dependent and no person will be considered as a dependent of more than one employee. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Members should file with the primary plan first and then the secondary plan. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

BIRTHDAY RULE: The Birthday Rule is applied for determining the primary carrier for payment of dental benefits for dependent children. The plan of the parent whose birthday, month and day, falls first in the calendar year is the primary carrier. For example, if your birthday is July 9 and your spouse's birthday is October 27, your dental plan will be primary. Payment claims for dependent children should be submitted to the primary plan first, and then to the secondary plan, enclosing a copy of the payment voucher from the primary plan.

EXPENSES NOT COVERED: Covered Expenses will not include, and no payment will be made for, expenses incurred for:

1. treatment solely for the purpose of cosmetic improvement.
2. replacement of a lost or stolen appliance.
3. replacement of a bridge, crown or denture within five years after the date it was originally installed.
4. replacement of a bridge, crown or denture which is or can be made usable according to common dental standards.
5. procedures, appliances or restorations (except full dentures) whose main purpose is to:
   a) change vertical dimension; or
   b) diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
   c) stabilize periodontally involved teeth; or
6. multiple bridge abutments.
7. a bridge or denture that replaces a tooth that was missing when the individual became eligible for dental benefits under this plan.
8. a surgical implant of any type, including any prosthetic device attached to it.
9. dental services that do not meet common dental standards.
10. services not included as Covered Dental Expenses in the UCE of FIT Welfare Trust Fund Dental Schedule.
11. services for which benefits are not payable according to the "General Limitations" section.

GENERAL LIMITATIONS: No payment will be made for expenses incurred for you or any one of your Dependents:

1. for or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party.
2. for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
3. for or in connection with a sickness which is covered under any workers compensation or similar law.
4. for charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance.

5. to the extent that payment is unlawful where the person resides when the expenses are incurred.
6. for charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family.
7. to the extent that they are more than Reasonable and Customary Charges.
8. for charges for unnecessary care, treatment or surgery.
9. to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program.
10. for or in connection with experimental procedures or treatment methods not accepted.
11. for any services covered under a "No Fault" policy.

GUARDED PROGNOSIS LIMITATION: If, in the opinion of the claims administrator, the longevity of the proposed or rendered treatment is limited, payment may be made in accordance with Plan provisions. However, any future benefits for additional services may be affected.

COSMETIC LIMITATION: Where there is more than one method of restoring a decayed or fractured tooth, one of which may result in a more aesthetic restoration than others, payment will be based on the least costly professionally acceptable treatment option.

IMPLANTOLOGY: Payment for a prosthetic device that is attached to one or more implants will be based on benefit allowances that would be paid if no implant was placed.

Self-Insured Dental Services
MetroDENT Premier
Participating Dental Program

This feature of your dental plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental bill. Since usual and customary dental charges generally exceed Dental Plan reimbursements, you will realize a significant savings in the cost of your dental care when you use a participating provider.

When you use a participating provider you will not incur any out-of-pocket expenses except in the following instances:

1. For services that are listed in the Schedule but for which the Plan will not pay, e.g.:
   a) where dental plan benefits exceed maximums.
   b) where procedure frequency limitations have been met.
   c) to satisfy the deductible, where applicable.

In these instances, the participating dentist's fees may not exceed the Maximum Charges as stated in the Schedule.

2. For non-covered services (there are a few procedures not covered by the Plan), you are not to pay more than the dentist's usual and customary fee for that service.

You should be aware that although several dentists may practice at the same location, only the dentist whose name appears on the list is a UCE of FIT Welfare Trust Fund Participating Dentist.

SELECTING A DENTIST- There are no restrictions on the use of a participating dentist. You are free to select the dentist or dental specialist of your choice. And of course, each family member may select his or her own dentist. You may utilize the services of a participating specialist whether or not you utilize the services of a participating general dentist for your routine care. You may change your dentist at any time for any reason. It is important to understand that the Fund does not recommend or endorse any particular dentist. You are responsible to select the dentist of your choice, participating or non-participating, and you should exercise the same care and apply the same criteria in selecting a participating dentist that you would in selecting a non-participating dentist.

SCHEDULING AN APPOINTMENT- After selecting a dentist from the directory, call the dental office for an appointment. Identify yourself as an eligible member of the UCE of FIT Welfare Fund MetroDENT Premier Dental Plan when scheduling your appointment . **Due to the fact that there are occasional additions and deletions, please verify that the dentist is still participating when scheduling your appointment. If you have any questions, please contact Self-Insured Dental Services at:**

516-396-5500 / 718-204-7172.

Please feel free to access our web site at
www.asonet.com

FILING A CLAIM- Participating dentists will handle all the necessary paperwork. You simply complete the Member Information and Assignment of Benefits section of your claim form and payment will be made directly to the dentist. You will be responsible for paying the dentist only in those instances stated above.

PREVENTIVE & DIAGNOSTIC	*PLAN PAYS*	*MEMBER PAYS*
ORAL EXAMINATION	40.00	
maximum - 3 per calendar year		
FULL MOUTH SERIES X-RAYS PANORAMIC FILM		
10 to 14 periapical and bitewing films	70.00	
maximum- once per 36 months		
PANORAMIC FILM	48.00	
maximum- once per 36 months		
INTRAORAL FILM		
periapical, first film	10.00	
maximum - 5 per six months		
bitewing	7.00	
maximum - 4 per six months		
OCCLUSAL FILM	18.00	
EXTRAORAL FILM, temporomandibular film	36.00	
maximum - one per 12 months		
EXTRAORAL FILM, anterior-posterior film	30.00	
PROPHYLAXIS, including scaling and polishing		
adult	50.00	
maximum- 3 per calendar year		
child	42.00	
maximum- 2 per calendar year		
SEALANT, permanent posterior,age 16	18.00	
BASIC RESTORATIVE		
SILVER AMALGAM FILLINGS PRIMARY or PERMANENT		
one surface	45.00	
two surfaces	48.00	
three surfaces or more	60.00	
COMPOSITE RESIN		
anterior	60.00	
Bonded Resin, Incisal Edge	80.00	
REINFORCEMENT PINS, per tooth	25.00	
METALLIC or PORCELAIN INLAY/ ONLAY		
one surface	200.00	
two surfaces	230.00	
three surfaces or more surfaces	260.00	
MAJOR RESTORATIVE		
CROWNS		
Resin with Metal	384.00	50.00
Porcelain fused to metal	400.00	50.00
Full cast	300.00	50.00
Full 3/4	300.00	50.00
MARYLAND BRIDGE RETAINER	180.00	
PONTIC		
Porcelain fused to metal	330.00	50.00
Any other pontic	330.00	50.00
PORCELAIN jacket, anterior teeth only	300.00	50.00
PORCELAIN LAMINATE-lab processed	258.00	
STAINLESS STEEL CROWN, primary tooth	120.00	
POST & CORE, prefabricated	75.00	
CAST POST & CORE	125.00	
ENDODONTICS		
x-ray evidence of satisfactory completion required		
PULP-CAP, direct	12.00	
PULPOTOMY	42.00	
ROOT CANAL THERAPY		
Anterior	225.00	50.00
Bicuspid	240.00	50.00
Molar	408.00	50.00
APICOECTOMY, 1st root	150.00	
APICOECTOMY, maximum per tooth	300.00	
RETROGRADE FILLING-per tooth	85.00	

PROSTHODONTIC REPAIRS

	PLAN PAYS	MEMBER PAYS
DENTURE REPAIRS		
Repairing body of broken denture	90.00	
Replacing broken teeth in a complete denture, per tooth	85.00	
Replacing broken teeth in a denture, no other repair		
first tooth	85.00	
each additional tooth	90.00	
Replacing or adding a clasp	85.00	
Adding teeth to partial denture to replace natural teeth not part of existing denture	78.00	
Rebasing or relining,laboratory process	125.00	
Rebasing or relining, office procedure	75.00	
Replacing or repairing facing on crown or pontic	60.00	
RECEMENTATION		
crown	30.00	
inlay	30.00	
bridge	40.00	

DENTURES

FULL DENTURE immediate or permanent	550.00	50.00
PARTIAL DENTURE, bilateral acrylic base	375.00	50.00
PARTIAL DENTURE, bilateral metal base	500.00	50.00
PARTIAL DENTURE, unilateral	210.00	
Obturator(not including denture)	78.00	

PERIODONTIC SERVICES

Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least four teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than four teeth are treated, payment will be pro-rated on the basis of four teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

Confirmation by periodontal charting and/or x-rays required

ROOT SCALING	
and bite correction, 4 or more teeth, *including prophylaxis,* per quadrant, once every 24 months, maximum of	
per quadrant	50.00
per visit, two or more quadrants	100.00
*PERIODONTAL MAINTENANCE procedure	60.00

*Above procedure has a maximum limitation of 4 per calendar year in combination with adult prophylaxis. Prophylaxis will not be covered if performed on the same day as periodontal maintenance.

SURGICAL PERIODONTICS		
GINGIVAL SURGERY, maximum for any combination of gingivectomy, muco-buccal surgery, graft, per quad of at least 4 teeth	132.00	
OSSEOUS SURGERY, including gingival surgery, per quadrant of at least 5 teeth	360.00	50.00
*OSSEOUS GRAFT, single site	132.00	

* Above procedure is limited to to 2 sites per quadrant. Once every 36 months

EXTRACTIONS

	PLAN PAYS	MEMBER PAYS
ROUTINE EXTRACTION	54.00	
SURGICAL EXTRACTION	110.00	
must be demonstrated by pre-op x-ray		
impaction-soft tissue	115.00	
Impaction-partial bony	185.00	
Impaction-complete bony	225.00	
SURGICAL REMOVAL residual roots	90.00	
EXPOSURE of unerupted tooth	160.00	
ROOT RESECTION	150.00	
HEMISECTION	120.00	

Claims for impactions must be submitted to the medical carrier first, since these plans cover excision of impacted teeth. After you have received payment from the medical carrier, you should attach the Explanation of Payment form to a completed S.I.D.S form, and then submit them to S.I.D.S

ORAL SURGERY

REMOVAL OF CYST, including extraction	125.00	
ALVEOLOPLASTY-per quad	125.00	
BIOPSY excluding lab fees	75.00	
CLOSURE of oral antral fistula	78.00	
FRENULECTOMY	95.00	

ADJUNCTIVE SERVICES

SPACE MAINTAINER	150.00	
BRUXISM APPLIANCE	120.00	
SPECIALIST CONSULTATION	0.00	75.00
PALLIATIVE TREATMENT, Emergency visit for relief of pain. No other Treatment that visit	30.00	
GENERAL ANESTHESIA/IV SEDATION		
first 30 minutes only	90.00	50.00
additional 15 minutes	42.00	

ORTHODONTIC SERVICES

DIAGNOSIS AND INITIAL APPLIANCES	516.00	50.00
ACTIVE TREATMENT	60.00	
Per month, maximum 24 months		
PASSIVE ORTHODONTIC TREATMENT	60.00	
per 3 months, maximum 9 months		
RETAINER	120.00	

UCE of FIT Welfare Trust Fund

Seventh Avenue at 27th Street
New York, NY 10001

(212) 217-7939

DENTAL PLAN ADMINISTRATOR

SELF-INSURED DENTAL SERVICES
P.O. BOX 9005
LYNBROOK, NY 11563

516-396-5500

Please feel free to access our web site at
www.asonet.com