

UPSE BENEFIT FUND

SUMMARY DENTAL PLAN DESCRIPTION

Town of Islip - Blue Collar Unit

GENERAL INFORMATION

Enrollment

Coverage under the Plans offered by the UPSE Benefit Plan is not automatic. You must first **enroll** yourself and your dependents in the Plan. There is one enrollment card which enrolled you in the Plan(s) negotiated for you. If you have not already done so, you can obtain an enrollment card by calling the Plan at **631.738.8773**

Enrollment in the plan does not vest any right in the covered employee except the right to receive benefits under the plan only so long as payments are being received by the Plan on behalf of the employees.

Who is Eligible

You are eligible for coverage under the Plan:

Full-Time Employee

- If you are a full-time employee in a UPSEU represented bargaining unit that has negotiated with your employer for Fund coverage.

Part-Time Or Seasonal Employee

- If your collective bargaining agreement includes coverage for certain part-time and seasonal employees.

NOTE: An employee may not be covered both as an employee and as a dependent of an employee. If both parents are Fund members, coverage for children may not be claimed under both parents.

Dependents

- If your collective bargaining agreement includes dependent coverage, your dependents become eligible the same time you do.
- You must notify the Fund promptly of changes in dependent status to ensure that new dependents receive the appropriate coverage and to avoid responsibility for charges incurred by an individual after he or she has ceased to be your dependent.

Dependents Include:

- Your spouse, provided he or she is not legally separated from you, or your domestic partner.
- Your unmarried children, including stepchildren who permanently reside with you and legally adopted children, under the age of 19.
- Your legal ward under the age of 19 who permanently resides with you pursuant to a court order awarding legal guardianship to you.
- Any child or ward described above, regardless of age, who is incapable of self support by reason of mental or physical disability, provided he or she became so disabled prior to reaching age 19.
- **Any child or ward described above under the age of 25 who is a full time student** (minimum of 12 undergraduate or 6 graduate credit hours) enrolled in a regionally accredited college or university and working toward a Bachelor's Degree (e.g., B.A. or B.S.), Master's Degree (e.g. M.A. or M.S.) Or Associate's Degree (e.g., A.A. or A.S.). Technical courses of short duration do not qualify, even if a diploma is awarded. The Fund requires that **current proof of student status be provided annually** (letter or statement from the college's Registrar's Office or completion of student Status Form available from the Fund).

NOTE: This form is used only to update/validate the UPSEU dependent student eligibility file. Your Health Insurance carrier may require different or additional evidence of dependent student enrollment. We suggest that you obtain a letter of student enrollment from the school registrar to avoid delays in processing health insurance claims for your child.

C.O.B.R.A.

- If you become ineligible for Fund coverage because of retirement, termination, layoff, leave without pay or reduction in hours, you may have certain rights to continue Plan coverage through C.O.B.R.A. Under these and certain additional circumstances, your spouse and/or dependent(s) may have rights to continue coverage through C.O.B.R.A as well.
- Before your payroll status changes, ask your employer for details about continuing coverage through C.O.B.R.A..

Appeal Procedure

- If you feel that you did not receive full benefits, you may appeal to the Director of the Fund.
- Send a letter to the Director explaining why you feel you did not get the full amount to which you were entitled. Include copies of any supporting documentation.
- This procedure is **not** designed to cover clerical mistakes on claims, which may be corrected by a phone call to the Fund.
- Nor is it meant for services clearly not covered by the Plans or for exemptions to or waivers of required waiting periods.

DENTAL PLAN

How To Use This Plan

- You may use any licensed dentist for dental care.
- Participating Sele-Dent dental offices in New York State have an agreed fee schedule for covered services, whether payment is made by you or by the Fund through an assignment of benefits.
- If you would like a copy of our current participating Dentist Directory call Sele-Dent at **800.520.3368**.
- If you choose a non-participating dentist, and are charged more than the amount listed under the schedule of allowances, you must pay the difference. (See schedule of allowances.)
- All dentist's have the necessary claim forms. Do not sign the bottom of the claim form until all of the work has been completed.

The Fund does not recommend that you use any particular dentist, either participating or non-participating.

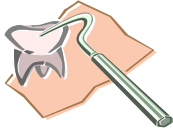
Maximum Benefit - Dental Plan

- There is a \$1,700.00 a year maximum on dental benefits.
- \$1,700.00 a year of covered dental benefits is available for *each* member and dependent.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, we are assuming liability for up to the first \$1700.00 of *covered* dental work per year. This maximum does not apply to orthodontia.
- We encourage those about to undergo extensive dental treatment to discuss those plans with the dentist beforehand. There are often less expensive alternatives available which will provide high quality dental care.

Pre-Authorization of Benefits

- Whenever the estimated cost of a recommended dental treatment exceeds \$250.00, **it must be submitted to Sele-Dent before work begins.**
- Use a dental claim form for this submission, and include the related x-rays.
- After review, Sele-Dent will notify the member and the dentist of the benefits payable based upon the treatment plan.
- In determining the amount of benefits payable, consideration will be given to alternate procedures that will accomplish a professionally acceptable result.
- If the member and the dentist agree to a more expensive method of treatment than that pre-authorized by Sele-Dent, the amount exceeding the pre-authorization will not be paid by Sele-Dent even if it would otherwise be a covered service.
- if you have work done for over \$250.00 without submitting a pre-authorization first, your claim will be reviewed under the alternate treatment provision.
- We strongly recommend that whenever you are discussing your treatment plan with your dentist, you clearly understand what is being proposed. If we recommend alternate benefits, you should also discuss this with your dentist.

A pre-authorization is not a guarantee of benefits. Payment is always subject to eligibility at the time of service.



**DENTAL PLAN SCHEDULE OF
ALLOWANCES COVERED SERVICES**



DIAGNOSTIC SERVICES

CLINICAL ORAL EXAMINATION, **includes diagnosis & charting** (*once every 6-months*) \$18.70

DENTAL RADIOGRAPHS

Intra-oral complete series, including bitewings (*1 per 3 years must include 12 films including bitewings*)
 X-rays, **full mouth** (*incl bitewings*) 41.80
 X-rays, **Intra-oral** (*first single film*) \$8.80
 X-rays, **Intra-oral additional film each** \$5.50
 X-rays, **Bitewing additional** (*first single film*) \$8.80
 X-rays, **Bitewings 2 films** \$13.20
 X-rays, **Bitewings 4 films** \$22.00
 X-rays, **Panoramic** (*1 per 3 years*) \$31.90

TEST AND LABORATORY EXAMINATIONS

Pulp vitality test (*1 per year*) \$7.00
Diagnostic casts, upper and/or lower (*1 per lifetime*) \$19.00

PREVENTIVE SERVICES - (*Cleaning, including scaling and polishing*)

Cleaning, including scaling and polishing
Dental prophylaxis, adult-14 yrs and over (*1 time in 6 months*) \$36.30
Dental prophylaxis, child-under 14 years (*1 time in 6 months*) \$26.40
Periodontal maintenance- including scaling, root planing curettage (*1time in 6 months*) \$33.00

TREATMENT -

Fluoride, up to age 18 years (*once annually*) \$13.20
 X **Space maintainers, fixed unilateral** \$71.50
Space maintainers, fixed bilateral \$110.00
Space maintainers, removable unilateral \$27.50

RESTORATIVE - FILLINGS (*1 time in 6 months*)

Amalgam Restorations - (*including polishing*).
Amalgam- one surface - primary \$26.40
Amalgam- two surfaces - primary \$36.30
Amalgam- three surfaces or more surfaces - primary \$44.00
Amalgam-one surface permanent \$36.30
Amalgam-two surfaces permanent \$55.00
Amalgam- three surfaces or more surfaces - permanent \$66.00

RESIN-BASED COMPOSITE RESTORATIONS - (*6 upper and lower anterior only*)

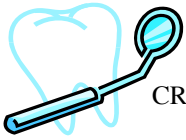
One surface \$47.30
Two surfaces \$52.80
Three or more Surfaces \$66.00
Class IV Incisal edge \$88.00

RESIN-BASED COMPOSITE RESTORATIONS - (*6 upper and lower anterior only*)

Resin One surface, posterior - primary \$27.50
Resin Two surface, posterior - primary \$38.50
Resin Three or more Surfaces, posterior - primary \$49.50
Resin One surface, posterior - permanent \$38.50
Resin Two surface, posterior - permanent \$55.00
Resin Three or more Surfaces, posterior - permanent \$66.00

METALLIC ONLAY AND/OR INLAY RESTORATIONS - (*Once in five years*)

Three Surfaces in lieu of crown \$187.00



CROWNS - SINGLE RESTORATIONS (*ONLY once in 5 years*)

Resin, with metal	\$302.50
Porcelain	\$330.00
Porcelain, with metal	\$357.50
Porcelain, with gold	\$330.00
Metallic (full cast)	\$302.50

OTHER RESTORATIVE SERVICES

Recement crown	\$27.50
Stainless Steel crown, primary teeth	\$71.50
Crown, temporary (fractured tooth)	\$71.50
Post and core (in addition to crown)	\$93.50
Porcelain in lieu of crown	\$209.00

ENDODONTICS

Pulp capping, (excluding restoration)	\$15.40
Therapeutic Pulpotomy (primary teeth only)(excluding restoration)	\$49.50

Root Canal Therapy (*includes x-rays, pulp removal, filling and follow-up care Pre and Post operative x-rays required*)

One canal	\$275.00
Two canals	\$330.00
Three or more canals	\$446.60

Periapical Services

Apicoectomy, per tooth (by report)	\$223.30
Apicoectomy, additional root (by report)	\$104.50
Retrograde filling, first tooth	\$137.50
Root amputation; not hemisection	\$170.50

PERIODONTICS (*Surgical Services one per quadrant per 36 months*)

36 months maximum full mouth \$1,100.00

Gingivectomy, or gingivoplasty per quadrant	\$330.00
Gingivectomy, or gingivoplasty per sextant	\$181.50
Osseous surgery, including flap entry and closure per quadrant (under age 22 by report)	\$440.00
Non-Surgical Services - 12 month Maximum Full Mouth	\$330.00
Periodontal root planning and scaling per treatment (Under age 22 by report)	\$82.50
Localized delivery of chemo therapeutic agents (By report)	\$220.00

PROSTHODONTICS (REMOVABLE Partial and Full Dentures) (*Replacements not more than once every five years*)

COMPLETE DENTURES(*including adjustments & recline for 6 months*)

Complete Upper	\$418.00
Complete Lower	\$418.00

PARTIAL DENTURES (*including adjustments & recline doe 6 months*)

Partial upper acrylic base with rests & clasps	\$253.00
Partial lower acrylic base with rests & clasps	\$253.00
Upper partial - cast base & clasps - acrylic saddles	\$451.00
Lower partial - cast base & clasps - acrylic saddles	\$451.00

REPAIRS TO FULL/COMPLETE DENTURES

Repair acrylic saddles or base	\$60.50
Repair cast frame work	\$121.00
Repair or replace broken clasp	\$121.00
Repair or replace broken tooth, per tooth	\$60.50
Add tooth to existing partial denture	\$99.00

REBASE AND RECLINE PROCEDURES - (*once in three years*)

Rebase and reline complete upper	\$154.00
Rebase and reline complete lower	\$154.00
Rebase and reline partial upper denture	\$121.00
Rebase and reline partial lower denture	\$121.00



PROSTHODONTICS (FIXED)

Once in five years per unit Fixed bridges, each abutment & each pontic constitutes a unit in a bridge

BRIDGE PONTICS

Pontic, Cast \$247.50

Porcelain fused to metal \$352.00

Porcelain fused to gold \$352.00

Resin fused to metal \$253.00

Acid etch bridge retainer, Maryland Type \$110.00

BRIDGE RETAINERS - Crowns

Resin fused to metal \$253.00

Porcelain fused to metal \$385.00

Porcelain fused to gold \$385.00

3/4 cast gold \$275.00

Full cast \$363.00

Recementation of Bridge \$38.50

ORAL SURGERY *(Extractions - includes anesthesia & post operative care)*

Single tooth

Surgical removal or erupted tooth - bone & suture \$110.00

Removal of impacted tooth - soft tissue \$132.00

Removal of impacted tooth - partially bony \$198.00

Removal of impacted tooth - completely bony \$313.50

SURGICAL PROCEDURES *- Supplement to other medical and/or dental benefits not to exceed actual charges*

Closure of oral antral fistula \$231.00

Surgical exposure of impacted or erupted tooth for orthodontics purposes, including attachments . \$308.00

Biopsy hard \$159.50

Biopsy soft \$110.00

Alveoplasty in conjunction with extractions (routine) \$95.70

Maximum per arch \$95.70

Alveoplasty not in conjunction with extractions \$159.50

Maximum per arch \$159.50

Removal of exostosis - Maxilla or mandible study model required \$165.00

Incision and drainage, abscess intraoral \$79.20

Incision and drainage, abscess extraoral \$191.40

OTHER PROCEDURES

Frenulectomy, frenotomy or frenectomy separate procedure \$223.30

Excision of hyperplastic tissue per arch separate procedure \$255.20

Unspecified oral surgical procedure *By Report*

ORTHODONTICS PROCEDURES *(Maximum per case \$2,160.00)*

Coverage is for dependent children only to age 18 (or 21)

Pre-orthodontic treatment visit \$110.00

Orthodontic appliances, including retainers (inceptive and removable therapy NOT covered) \$330.00

Active Orthodontics Therapy (maximum period 24-months)

Monthly orthodontic treatment \$71.50

Orthodontic Services MUST be rendered by Board qualified specialists.

OTHER SERVICES

Palliative (emergency) treatment once annually \$22.00

Consultation (second opinion) - once annually different office \$95.70

House call (patient immobile) - once annually \$55.00

Hospital call - once per month \$55.00

Office visit \$19.80