

THE SIDS/UFT PARTICIPATING DENTIST PROGRAM

The SIDS/UFT Participating Dentist Program was organized by SIDS in cooperation with the UFT Welfare Fund in 1979 to provide quality dental care to active and retired members of the United Federation of Teachers and their families. More than half of the 250,000 persons who are currently eligible for UFT Welfare Fund benefits utilize the services of network dentists. You are invited to apply for membership in the provider network.

Membership in the network is select and limited based on geographic location and professional qualification. The limited size of the provider panel, the extensive distribution of UFT Welfare Fund members, its strong endorsement by the Fund and the favorable reputation the SIDS/UFT provider network has earned over the years has made this an extremely successful program.

Scroll down to view a representative list of network fees and plan provisions. The plan has no maximum or deductible. If a patient is eligible for benefits under an additional group dental plan other than the UFT Welfare Fund plan, you are entitled to the benefits available from both plans. A more complete list of fees and plan provisions is available from SIDS — 516-396-5508. By scrolling down you can also obtain an application to join the network.

SIDS prepares, prints and distributes instructive and promotional materials to UFT Welfare Fund members publicizing the many advantages of the plan. SIDS staff members are readily available by phone, fax or email to assist dentists and their patients by providing information regarding plan provisions, helping expedite claims payments, responding to patient requests for clarification of coverage and charges and providing other day to day assistance.

The cost of providing these administrative and promotional services, which are fundamental to the success of this program, is underwritten by a membership fee of \$50 per participating office per month.

UFT members are highly educated professionals with an above average dental awareness who are exceptionally motivated with respect to their oral health and accustomed to excellent professional care. Should you apply and be accepted on the panel, you will have the opportunity to bring patients of the highest caliber and standing into your practice.

If you believe membership in this Program will be beneficial to your practice, I urge you to complete and return the application promptly.

If you have any questions or require clarification or additional information, please do not hesitate to call SIDS at 516-396-5501.



UFT WF SCHEDULE OF COVERED SERVICES, PLAN ALLOWANCES & PATIENT CO-PAYS

				PLAN PAYS	PATIENT PAYS	ALLOWABLE SURCHARGE
DIAGNOSTIC						
D0120	D0140	D0150	ORAL EXAMINATION	35.00		
		D0210	COMPLETE PERIAPICAL SERIES	50.00		
	D0220	D0230	PERIAPICAL X-RAY (SINGLE FILM)	6.00		
		D0240	OCCLUSAL X-RAY	15.00		
	D0250	D0260	EXTRAORAL-(EACH FILM)	15.00		
	D0270	D0277	BITEWING-(EACH FILM)	6.00		
		D0321	X-RAY (TMJ FILM)	30.00		
		D0330	PANORAMIC FILM	50.00		
PREVENTIVE						
	D1110	D1120	PROPHYLAXIS	45.00		
		D1351	SEALANT-PER TOOTH	30.00		
	D1510	D1520	SPACE MAINTAINER	75.00	100.00	
RESTORATIVE						
		D2140	SILVER FILL-1 SURFACE PRIMARY OR PERMANENT	50.00		
		D2150	SILVER FILL-2 SURFACES PRIMARY OR PERMANENT	60.00		
	D2160	D2161	SILVER FILL-3 OR MORE SURFACES PRIMARY OR PERMANENT	70.00		
D2330	D2331	D2332	RESIN BASED COMPOSITE RESTORATION, ANTERIOR	65.00		
		D2335	RESIN BASED COMPOSITE INCLUDING THE INCISAL ANGLE	80.00		
		D2391	RESIN BASED COMPOSITE POSTERIOR 1 SURFACE	50.00		◆
		D2392	RESIN BASED COMPOSITE POSTERIOR 2 SURFACES	60.00		◆
	D2393	D2394	RESIN BASED COMPOSITE POSTERIOR 3 OR MORE SURFACES	70.00		◆
		D2510	INLAY METALLIC-1 SURFACE	150.00		
		D2520	INLAY METALLIC 2 SURFACES	175.00		
		D2530	INLAY METALLIC 3 OR MORE SURFACES	200.00		
	D2610	D2650	INLAY, CERAMIC OR COMPOSITE - 1 SURFACE	150.00		◆
	D2620	D2651	INLAY, CERAMIC OR COMPOSITE - 2 SURFACES	175.00		◆
	D2630	D2652	INLAY, CERAMIC OR COMPOSITE - 3 OR MORE SURFACES	200.00		◆
		D2710	RESIN-BASED COMPOSITE CROWN (INDIRECT)	150.00	50.00	
		D2721	CROWN-RESIN WITH BASE METAL	270.00	50.00	
	D2720	D2722	CROWN-RESIN WITH NOBLE METAL	270.00	50.00	◆◆
		D2740	CROWN-PORCELAIN/CERAMIC	325.00	50.00	
		D2751	CROWN-PORCELAIN WITH BASE METAL	375.00	50.00	
	D2750	D2752	CROWN-PORCELAIN WITH NOBLE METAL	375.00	50.00	◆◆
		D2781	CROWN-3/4 CAST	225.00	50.00	
		D2791	CROWN-FULL CAST WITH BASE METAL	250.00	50.00	
D2790	D2792	D2794	CROWN-FULL CAST WITH NOBLE OR TITANIUM METAL	250.00	50.00	◆◆
		D2930	PREFABRICATED SS CROWN-PRIMARY TOOTH	150.00		
	D2915	D2920	RECEMENT CROWN OR INLAY	15.00		
		D2951	PIN RETENTION-PER TOOTH	12.00		
		D2952	CAST POST & CORE	125.00		
		D2954	PREFABRICATED POST & CORE	60.00		
		D2960	LABIAL VENEER, CHAIRSIDE	215.00		
	D2961	D2962	LABIAL VENEER, LABORATORY FABRICATED	215.00		◆
		D2980	CROWN OR PONTIC REPAIR BY REPORT	50.00		



UFT WF SCHEDULE OF COVERED SERVICES, PLAN ALLOWANCES & PATIENT CO-PAYS

		PLAN PAYS	PATIENT PAYS	ALLOWABLE SURCHARGE	
	D3320	ROOT CANAL THERAPY-BICUSPID	250.00	50.00	
	D3330	ROOT CANAL THERAPY-MOLAR	425.00	50.00	
	D3346	ROOT CANAL THERAPY-RETREATMENT,ANTERIOR	175.00	175.00	
	D3347	ROOT CANAL THERAPY-RETREATMENT,BICUSPID	250.00	250.00	
	D3348	ROOT CANAL THERAPY-RETREATMENT,MOLAR	425.00	425.00	
D3410	D3421	D3425	APICOECTOMY FIRST ROOT	275.00	
	D3426	APICOECTOMY, MULTIPLE ROOTS, MAX PER TOOTH	425.00		
	D3430	RETROGADE ROOT FILLING PER ROOT	75.00		
	D3450	ROOT AMPUTATION	100.00		
	D3920	HEMISECTION	100.00		

PERIODONTICS

	D4210	GINGIVAL SURGERY FOUR OR MORE TEETH PER QUAD	110.00		
	D4211	GINGIVAL SURGERY 1-3 CONTIGUOUS TEETH PER QUAD	55.00		
	D4249	CLINICAL CROWN LENGTHENING, PER SITE	0.00	225.00	◆◆◆
	D4260	OSSEOUS SURGERY-4 OR MORE TEETH PER QUAD	300.00	50.00	
	D4261	OSSEOUS SURG -1-3 CONTIGUOUS TEETH PER QUAD	150.00	50.00	
D4263	D4264	BONE REPLACEMENT GRAFT PER SITE	110.00		
	D4266	GUIDED TISSUE REGENERATION RESORBABLE BARRIER/SITE	110.00		
	D4267	GUIDED TISSUE REGENERATION NON-RESORBABLE BARRIER/SITE	110.00		◆
	D4341	PERIODONTAL SCALING & ROOT PLANING-PER QUAD	35.00		
	D4342	SCALING & ROOT PLANING-FEWER THAN 4 TEETH PER QUAD	30.00		
	D4910	PERIODONTAL MAINTENANCE PROCEDURE	70.00		

PROSTHODONTICS

	D5110	D5120	COMPLETE DENTURE MAXILLARY OR MANDIBULAR	375.00	50.00	
	D5130	D5140	IMMEDIATE DENTURE MAXILLARY OR MANDIBULAR	375.00	50.00	
	D5211	D5212	PARTIAL DENTURE-ACRYLIC BASE	275.00	50.00	
	D5213	D5214	PARTIAL DENTURE CAST METAL FRAMEWORK	375.00	50.00	
	D5281		UNILATERAL PARTIAL DENTURE, CAST BASE	175.00	50.00	
	D5510		REPAIR BROKEN COMP DENT BASE	90.00		
	D5520		REPLC MISS/BRKN TTH-COMP DENT	35.00		
	D5630		REPAIR OR REPLACE BROKEN CLASP	63.00		
	D5640		REPLACE BROKEN TEETH-PER TOOTH	65.00		
	D5650		ADD TTH TO EXISTING PART DENT	90.00		
	D5730	D5731	RELIN COMPLETE DENTURE-CHAIRSIDE	85.00		
	D5740	D5741	RELIN PARTIAL DENTURE-CHAIRSIDE	85.00		
	D5750	D5751	RELIN OR REBASE COMPLETE DENTURE-LABORATORY	165.00		
	D5760	D5761	RELIN OR REBASE PARTIAL DENTURE-LABORATORY	165.00		
D6010	D6040	D6050	SURGICAL PLACEMENT OF AN IMPLANT	0.00	1200.00	◆◆◆
D6065	D6066	D6067	IMPLANT SUPPORTED CROWN	375.00		◆
D6075	D6076	D6194	IMPLANT SUPPORTED RETAINER FOR PARTIAL DENTURE	375.00		◆
	D6211		PONTIC-CAST BASE METAL	275.00	50.00	
D6210	D6212		PONTIC CAST NOBLE METAL	275.00	50.00	◆
	D6241		PONTIC-PORCELAIN FUSED TO BASE METAL	275.00	50.00	
D6240	D6242		PONTIC-PORCELAIN FUSED TO NOBLE METAL	275.00	50.00	◆
	D6251		PONTIC-RESIN WITH BASE METAL	275.00	50.00	
D6250	D6252		PONTIC-RESIN WITH NOBLE METAL	275.00	50.00	◆



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			PLAN PAYS	PATIENT PAYS	◆◆◆ ALLOWABLE SURCHARGE
D6750	D6752	CROWN-PORCELAIN WITH NOBLE METAL	375.00	50.00	◆◆
	D6791	CROWN-FULL CAST BASE METAL	250.00	50.00	
D6790	D6792	D6794 CROWN-FULL CAST NOBLE METAL OR TITANIUM	250.00	50.00	◆◆
	D6930	RECEMENT BRIDGE	15.00		
	D6980	REPAIR OR REPLACE FACING	50.00		

ORAL SURGERY

	D7140	EXTRACTION OF ERUPTED TOOTH	45.00		
	D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	120.00		
	D7220	REMOVAL OF IMPACTED TOOTH, SOFT TISSUE	120.00		
	D7230	REMOVAL OF IMPACTED TOOTH, PARTIALLY BONY	200.00		
	D7240	REMOVAL OF IMPACTED TOOTH, COMPLETELY BONY	300.00		
	D7241	REMOVAL OF COMPLETE BONY IMPACTION WITH COMPLICATIONS	300.00		◆
	D7250	SURGICAL ROOT RECOVERY	120.00		
	D7260	CLOSURE OF ORAL ANTRAL FISTULA	65.00		
	D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	150.00		
	D7283	PLACEMENT OF A DEVICE TO AID ERUPTION OF IMPACTED TOOTH	0.00		◆
D7285	D7286	BIOPSY OF ORAL TISSUE, EXCLUDING LAB FEE	55.00		
D7310	D7320	ALVEOLOPLASTY PER QUADRANT	65.00		
	D7450	EXCISION OF BENIGN CYST OR TUMOR UP TO 1.25 cm.	65.00		
	D7960	FRENULECTOMY	65.00		

ORTHODONTICS

D8080	D8090	DIAGNOSIS AND PLACEMENT OF FIXED APPLIANCES FOR COMPREHENSIVE ORTHODONTIC TREATMENT	525.00	100.00	
	D8670	ACTIVE TREATMENT PER MONTH - MAX 24 MONTHS	50.00	5.00	
		PASSIVE TREATMENT-PER 3 MONTHS-MAX 9 MONTHS	50.00	5.00	
	D8680	RETAINER PLACEMENT	100.00	100.00	

MISCELLANEOUS

	D9110	PALLIATIVE-EMERGENCY TREATMENT	30.00		
	D9310	CONSULTATION	0.00	75.00	◆◆◆
	D9940	OCCLUSAL GUARD	100.00	100.00	
	D9951	OCCLUSAL ADJUSTMENT - LIMITED	35.00		

ANESTHESIA

D9220	D9241	GENERAL ANESTHESIA/IV SEDATION, FIRST 30 MINUTES	75.00	50.00	
D9221	D9242	GENERAL ANESTHESIA/IV SEDATION ADDITIONAL 15 MINUTES	35.00	50.00	
D9230	D9248	INHALATION/NON-INTRAVENOUS ANALGESIA	35.00		

◆ THIS IS NOT A COVERED SERVICE BUT MAY BE PAID IN PART BY THE PLAN AS AN ALTERNATE BENEFIT. IN THAT CASE THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN YOUR USUAL FEE AND ANY PAYMENT RECEIVED FROM THE PLAN.

◆◆ THE PLAN BENEFIT IS BASED ON A BASE METAL RESTORATION. PATIENTS OPTING FOR UPGRADED METALS ARE RESPONSIBLE FOR THE ADDITIONAL COST.

◆◆◆ THERE IS NO PLAN BENEFIT FOR THIS SERVICE. THE PATIENT IS RESPONSIBLE FOR 100% OF THE ALLOWABLE FEE.

SIDS PARTICIPATING PROVIDER ORGANIZATION APPLICATION

**P.O BOX 9005
Lynbrook, New York 11563
516-396-5501 Fax: 516-396-5594**

UNITED FEDERATION OF TEACHERS WELFARE FUND

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DENTIST INFORMATION

Name _____ Lic No. _____ Taxpayer ID No. _____
Street Address _____ City _____
County _____ State _____ Zip Code _____
Office Telephone(____) _____ Fax(____) _____ Date of Birth _____
Dental School _____ Degree _____ Year Graduated _____
Continuing Education Courses (Description & Dates) _____

Professional Positions and Associations _____

Would you be willing to participate as a member of a professional review board? _____

Office Information

GP _____ Specialist _____ Bd. Certified _____ Bd. Eligible _____ Do you limit your practice? _____
Sole Ownership _____ Partnership _____ Group Practice _____ Franchise _____ Number of years at this location? _____
List the names of all principals and associates in the practice _____

Number of operatories equipped and in use? _____ Is space available for expansion? _____
Method of sterilization: _____ Ultrasonic _____ Cold _____ Autoclave _____ Chemiclave _____ Dry Heat _____
Number of handpieces: _____ Number of standard X-ray units _____ Panoramic Unit _____ Are units certified? _____
Special facilities and services: _____

Office hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____
No. of Dentists _____ No. of Hygienists _____ No. of Dental Assistants _____ No. of Clerical Support Personnel _____

Other similar Provider Networks in which you participate _____

Malpractice Insurance Carrier _____ Policy # _____ Liability Limit _____

Do you and your staff routinely follow all ADA and CDC guidelines for infection Control? _____

- Have you ever been reprimanded or fined by a state disciplinary agency? _____
- Has your license to practice dentistry ever been revoked or suspended? _____
- Has your privilege to prescribe drugs ever been limited? _____
- Has your hospital privileges ever been revoked? _____
- Have you ever been convicted of a crime? _____

Signature: _____ Date: _____