Eastern Suffolk BOCES
Group #115

Summary of Benefit for Full-Time Members Eff 1/1/2020:

Annual maximum $1,750.00 individual

Ortho annual max $500.00, **deductible** $25.00 Appliance $200.00, $52.50 monthly (No age limit) INVISALIGN will be covered through a Dentist Only and when the treatments are done in an office with monthly/quarterly claim submission. SMILE DIRECT or any other MAIL ORDER TRAYS are **NOT** covered.

Perio annual max $500.00, **deductible** $25.00 individual and $50 family for Out of Network

Proof of Enrollment: handled by Sele-Dent, Inc. (Ages 19 – 25, full-time student)
Pre-Authorizations: Any claims over $325.00 only suggested.

In Network:
Type A and Type B work paid at 100% of the Sele-Dent fee schedule.

Out of Network:
Type A work paid at 80% and Type B work paid at 60% based on usual and customary, member pays balance. Major and Perio work are subject to a $25.00 individual deductible and a $50.00 family deductible.

FREQUENCIES:

- **No limitations or frequencies on Type A services** (exam, prophy, fluoride, sealants, full-mouth series, panoramic x-rays
- **Perio:** No frequency, all four quads same day
- **Major work:** 1-year replacement on major
- **Missing Tooth:** Covered

Exclusions:
Implants and Veneers: Not covered

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