



PROFESSIONAL DENTAL CARE



## Correction Captains Association Security Benefit Fund Group #131

### Summary of Benefit for Active Members **effective 1/1/2020**

**Annual maximum** \$3,500.00 individual

**Individual Ortho Lifetime max** \$3,500 Appliance \$600, active monthly visits \$95 for 24 months, \$60 monthly for two passive treatments. Retention appliance \$500 - No Age limit **\$100 deductible will be applied to the initial insertion of braces.**

#### **Pre-Authorizations:**

Any claims over \$500.00 must be pre-authorized.

#### **In Network/ UNICARE**

Providers are reimbursed 100% of either the Sele-Dent / UNICARE fee schedule or CCA Fund fee schedule, whichever applies. **\$100 One-time annual deductible and this will be deducted at two separate dental visits.**

#### **Out of Network:**

Providers are reimbursed 100% of the Fund's current out-of-network fee schedule. **\$150 One-time annual deductible and this will be deducted in three separate installments of \$50 per first three dental visits.**

#### **FREQUENCIES:**

- **Examination:** One every six months.
- **Prophylaxis:** One every six months.
- **Full mouth and Panoramic x-rays:** One every twelve months.
- **Bitewings X-ray: No Limitation**
- **Sealants:** No Frequency / No age limit
- **Fluoride:** Once every six months, up to age 19.
- **Perio:** No Frequency, all four quads same day.
- **Major work:** 36 Months replacement on crowns, bridges and dentures.
- **Missing Tooth:** Covered
- **Implants covered with mandatory pre-authorization**

#### **Mailing Address:**

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## Correction Captains Association Out-of-Network dental services schedule Group 131

<u>DIAGNOSTIC &amp; PREVENTATIVE</u>	<u>Plan Pays</u>
Oral Examination maximum	\$25
Full Mouth Services including bitewings	\$60
Periapical or Bitewing – First Film	\$6
Panoramic Film	\$50
Occlusal Film	\$15
Cephalometric Film	\$40
Prophylaxis, including scaling and polishing – two in a calendar year.	
Adult	\$50
Child to age 12 years maximum – two in a calendar year	\$35
Topical Application of Fluoride to age 19 maximum – one application in a calendar year	\$20
Sealant maximum – unrestored, permanent teeth only to age 19	\$30
Diagnostic Casts	\$25
Space Maintainer	\$150
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<u>BASIC RESTORATIVE</u>	<u>Plan Pays</u>
Silver Amalgam Fillings, primary teeth	
one surface	\$45
two surfaces	\$55
three or more surfaces	\$60
Silver Amalgam Fillings, permanent teeth	
one surface	\$45
two surfaces	\$55
three surfaces	\$65
four or more surfaces	\$70
Composite Resin, anterior or posterior teeth	
one surface	\$50
two surfaces	\$60
three or more surfaces	\$70
four or more surfaces including incisal angle	\$80
Pin Support, per tooth	\$25
Metallic or Porcelain Inlay	
one surface	\$200
two surfaces	\$230
three or more surfaces	\$260
Onlay in addition to Inlay	\$70

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**MAJOR RESTORATIVE**

*Crowns, bridges, and removable dentures are limited to once per three years & require per-operative periapical x-ray*

	Plan Pays
Crowns	
Acrylic Jacket (laboratory processed)	\$200
Porcelain Jacket	\$350
Plastic with Metal	\$375
Porcelain with Metal	\$425
Crowns	
Full Cast	\$350
Stainless Steel (primary tooth)	\$75
Porcelain Laminate	\$250
Post and Core, prefabricated	\$75
Post and Core, cast	\$125
Recement Crown or Inlay	\$30

**ORAL SURGERY**

Routine Extraction	\$50
Surgical Extraction must be demonstrated by submitted x-ray	
Retained Root	\$75
Root Removal	\$90
Impaction – Soft Tissue*	\$115
Impaction – Partial Bony*	\$185
Impaction – Complete Bony*	\$225
Surgical Exposure	
Impacted or Unerupted Tooth, for Ortho	\$160
Impacted or Unerupted Tooth, Aid Eruption	\$80
Alveoloplasty – Per Quadrant	\$125
Incision and Drainage	\$50
Biopsy	\$75

\*Members enrolled in GHI must submit claims for impactions to GHI first, since GHI covers excision of impacted teeth. A copy of the payment voucher from GHI may then be affixed to a Dental form and submitted to the fund for any additional benefits.

**PROSTHODONTICS**

*(Crowns, Bridges, and Removable Dentures are limited to once every three years)*

	Plan Pays
Complete or Immediate Denture	\$600
Partial Denture-Bilateral	
Acrylic Base	\$425
Cast Metal Base	\$600
Denture Repairs	
Broken Denture Base	\$90
Replace Tooth in Denture	\$85
Replace Broken Facing	\$100
Broken Cast Framework	\$90
Replace Broken Clasp	\$85
Add tooth to Existing Partial Denture	\$85
Add Clasp to Existing Partial	\$85
Denture Adjustment	\$35
Reline Complete Denture, Chairside	\$75
Reline Complete Denture, Laboratory	\$125
Reline Partial Denture, Chairside	\$50
Reline Partial Denture, Laboratory	\$100
Tissue Conditioning	\$40

**PROSTHODONTICS (Continued)**

*(Crowns, Bridges, and Removable Dentures are limited to once every three years)*

	Plan Pays
Bridge Abutment or Pontic	
Inlay – Two Surface	\$230
Inlay – Two Surface	\$260
Crown – Plastic with Metal	\$350
Crown – Porcelain fused to Metal	\$425
Crown – Full Cast	\$350
Maryland Bridge Retainer	\$230
Precision Attachment	\$125
Replacement Bridge	\$50

**ENDODONTICS**

*(x-ray of satisfactory completion required)*

	Plan Pays
Pulp Cap, Direct	\$10
Pulpotomy	\$60
Root Therapy	
One Canal	\$225
Two Canals	\$300
Three or More Canals	\$400
Apicoectomy, First Root	\$150
Apicoectomy, Maximum Per Tooth	\$300
Retrograde Filling	\$85
Hemisection	\$150

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**ADJUNCTIVE SERVICES**

	<u>Plan Pays</u>
Palliative Treatment Maximum	\$30
Specialist Consultation Maximum – Once in a Calendar Year, includes Exam	\$50
General Anesthesia – 1 <sup>st</sup> 30 Minutes Only	\$125
Intravenous Sedation – 1 <sup>st</sup> 30 Minutes Only	\$125
Bruxism Appliance	\$100

**PERIODONTICS**

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 five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five 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.

	<u>Plan Pays</u>
Periodontal Treatment – Per Visit	
Root Scaling & Subgingival Curettage with Prophylaxis	\$50
Maximum per year	\$200

**Periodontal Surgery**

Confirmed by charting and/or x-rays required per quadrant of at least five teeth, soft-tissue, gingivectomy or gingivoplasty, mucco-buccal surgery, soft tissue graft or vestibuloplasty.

	<u>Plan Pays</u>
Any combination, Max per Quad	\$100
Osseous Graft, Per Quadrant	\$250
Osseous Graft, Per Site	\$90
Pedicle Soft Tissue Graft	\$200
Free Soft Tissue Graft, Per Quadrant	\$250
Osseous Surgery Including Gingivectomy Maximum – One in 36 Months Maximum Per Quad	\$350

**ORTHODONTICS**

	<u>Plan Pays</u>
Lifetime maximum	\$3,500
Initial Orthodontic Appliance Full treatment – Fixed Appliance	\$600
Active Treatment Per Month of Treatment	\$95
Passive Treatment Per 3 Months of Treatment	\$60
Retention Appliance	\$500

**IMPLANT SERVICES**

	<u>Plan Pays</u>
Endosteal Implant	\$1,200
Subperiosteal Implant	\$1,200
Prefabricated Abutment	\$400
Custom Abutment	\$475
Abutment Supported Crown	\$675
Implant Supported Crown	\$97

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