



Correction Captains Association Retirees Security Benefit Fund - Group #132

Summary of Benefit for Retiree Members effective 1/1/26

Annual maximum \$2,500 individual

Ortho Lifetime max for dependent children under 19 \$3,000 Appliance \$600 (-\$100 deductible will apply at initial banding), active monthly visits \$100 for 24 months, retainer \$100.

Pre-Authorizations:

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

Annual Deductible of \$50 for all eligible participants, including dependents that apply to all services.

In Network/ UNICARE - Providers are reimbursed 100% of either the Sele-Dent / UNICARE fee schedule or CCA Fund fee schedule, whichever applies.

Out Of Network - Providers are reimbursed 100% of the CCA Out of Network Fee Schedule

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: 3-year replacement **on crowns, bridges and dentures with a co-pay of \$50 per tooth/per procedure.**
- No missing tooth/ waiting period.

Not covered:

- **Arestin, cone beam x-rays, hygiene instructions, Implants and any related procedures/services**

One Huntington Quadrangle, Suite 1C12 Melville, NY 11747
Toll Free 800-520-3368, PH 516-887-7566, FX 516-887-7896



Correction Captains Out-of-Network dental services schedule

Group #132

DIAGNOSTIC & PREVENTATIVE	Plan Pays
Oral Examination maximum – One every six (6) months	\$42
Full Mouth Services including bitewings	\$70
Periapical or Bitewing – First Film	\$10
Panoramic Film	\$60
Occlusal Film	\$20
Cephalometric Film	\$40
Prophylaxis, including scaling and polishing once every 6 months	
Adult	\$60
Child to age 12 years maximum – once every 6 months	\$45
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
Space Maintainer	\$155

BASIC RESTORATIVE

	Plan Pays
Silver Amalgam Fillings, primary teeth	
one surface	\$75
two surfaces	\$85
three or more surfaces	\$95
Silver Amalgam Fillings, permanent teeth	
one surface	\$75
two surfaces	\$85
three surfaces	\$95
four or more surfaces	\$100
Composite Resin, anterior or posterior teeth	
one surface	\$80
two surfaces	\$90
three or more surfaces	\$100
four or more surfaces including incisal angle	\$110
Pin Support, per tooth	\$30
Metallic or Porcelain Inlay	
one surface	\$225
two surfaces	\$255
three or more surfaces	\$285
Onlay in addition to Inlay	

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Fax:

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PROFESSIONAL DENTAL CARE

MAJOR RESTORATIVE

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

Crowns	
Acrylic Jacket (laboratory processed)	\$350
Porcelain Jacket	\$500
Plastic with Metal	\$300
Porcelain with Metal	\$575
Full Cast	\$500
Stainless Steel (primary tooth)	\$75
Porcelain Laminate	\$300
Post and Core, prefabricated	\$100
Post and Core, cast	\$150
Recement Crown	\$35
Recement Inlay	\$40

ORAL SURGERY

Routine Extraction	\$75
Surgical Extraction must be demonstrated by submitted x-ray	
Retained Root	\$110
Root Removal	\$115
Impaction – Soft Tissue*	\$150
Impaction – Partial Bony*	\$220
Impaction – Complete Bony*	\$260
Surgical Exposure	
Impacted or Unerupted Tooth, for Ortho	\$195
Impacted or Unerupted Tooth, Aid Eruption	\$115
Alveoloplasty – Per Quadrant	\$150
Incision and Drainage	\$75
Biopsy	\$100

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

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PROFESSIONAL DENTAL CARE

PROSTHODONTICS

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

	Plan Pays
Complete or Immediate Denture	\$855
Partial Denture-Bilateral	
Acrylic Base	\$425
Cast Metal Base	\$650
Denture Repairs	
Broken Denture Base	\$100
Replace Tooth in Denture	\$95
Replace Broken Facing	\$100
Broken Cast Framework	\$100
Replace Broken Clasp	\$95
Add tooth to Existing Partial Denture	\$95
Add Clasp to Existing Partial	\$95
Denture Adjustment	\$45
Reline Complete Denture, Chairside	\$85
Reline Complete Denture, Laboratory	\$135
Reline Partial Denture, Chairside	\$60
Reline Partial Denture, Laboratory	\$110
Tissue Conditioning	\$50

PROSTHODONTICS (Continued)

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

	Plan Pays
Bridge Abutment or Pontic	
Inlay – Two Surface	\$255
Inlay – Two Surface	\$285
Crown – Plastic with Metal	\$550
Crown – Porcelain fused to Metal	\$600
Crown – Full Cast	\$525
Re-cement Bridge	\$60
Maryland Bridge Retainer	\$330
Precision Attachment	\$135

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PROFESSIONAL DENTAL CARE

ENDODONTICS

(x-ray of satisfactory completion required)

Plan Pays

Pulp Cap, Direct	\$20
Pulpotomy	\$70
Root Therapy	
One Canal	\$280
Two Canals	\$355
Three or More Canals	\$455
Apicoectomy, First Root	\$200
Apicoectomy, Maximum Per Tooth	\$350
Retrograde Filling	\$110
Hemisection	\$175

ADJUNCTIVE SERVICES

	<u>Plan Pays</u>
Palliative Treatment Maximum – Once in a Calendar Year	\$45
Specialist Consultation Maximum – Once in a Calendar Year, includes Exam	\$65
General Anesthesia – 1 st 30 Minutes Only	\$225
Intravenous Sedation – 1 st 30 Minutes Only	\$225
Bruxism Appliance	\$150

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	\$105
Maximum per year	\$420

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>
Osseous Graft, Per Quadrant	\$250
Osseous Graft, Per Site	\$140
Pedicle Soft Tissue Graft	\$250
Free Soft Tissue Graft, Per Quadrant	\$300
Osseous Surgery Including Gingivectomy Maximum – One in 36 Months Maximum Per Quad	\$400

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PROFESSIONAL DENTAL CARE

ORTHODONTICS	Plan Pays
Lifetime maximum	\$3,000
Initial Orthodontic Appliance Full treatment – Fixed Appliance	\$600
Active Treatment Per 24 Months of Treatment	\$100
Retainer	\$100

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