Group Dental For Members And Dependents

compbenefits

We are pleased to announce you are eligible for Dental Coverage offered by CompBenefits through your Credit Union. AT LAST, you have the opportunity to receive quality dental care and save money too!

After a $5.00 office visit co-payment, CompBenefits offers you these excellent benefits:

Exams.....No Charge	Routine Cleanings (Semi-Annual)..... No Charge
Routine X-Rays .....No Charge	Fluorides (Up to age 16) ..... No Charge

All Other Procedures are available at a savings of 25% - 50%. Refer to the Plan's Benefit Schedule and Co-payments on the reverse side.

• Pre-existing conditions are covered • No deductibles • No maximum benefits limitations • No claims forms

CompBenefits has an extensive list of local Preferred Providers for your convenience. Select a dental office close to your home or work.

Convenient monthly payments will be made automatically through your Credit Union account. **Monthly rates are $12.78 for one subscriber: $24.26 for subscriber plus one dependent: and $32.40 for subscriber plus two or more dependents.** Your contract is for a minimum of one year.

Complete the attached application form now and return for processing. Your coverage will become effective upon receipt of your Identification Card; then phone your CompBenefits dentist for a convenient appointment.

Dental Plus…

Preferred Vision Care Program

Highlights:

- Savings up to 50% on frames or lenses
- Savings up to 60% off contact lenses

Hearing Aid Program-Beltone Centers

Highlights:

- 15% discount off the dispenser's regular list price on hearing aid products
- Over 70 models and hundreds of customized Beltone hearing aids to choose from

Should you desire assistance, please call CompBenefits 1-800-342-5209 (Customer Care) or Credit Union Insurance Center 1-800-432-0235 (National Toll Free)

Send Applications To: CompBenefits, 11550 N. Meridian St. Ste 275, Carmel, IN 46032

Complete Application Form

1. Be sure to list all family members to be included in coverage.
2. Select dental office from the Provider List . Insert the dental facility number on application.
3. Complete the authorization on the reverse side.
4. Sign where indicated "X" on both the application and the authorization for deduction.
5. Include first month's premium check payable to CompBenefits.
6. Send the application authorization for deduction and check to the address above. Deductions from your account will be made in accordance with the procedures established and communicated by the Credit Union.

Please remember to enclose the first month's premium with your application.

Completed applications, with correct premium, received by Home Office by the 10th of the month, will become effective on the 1st of the following month.

SOCIAL SECURITY NO.	LAST NAME	FIRST	MI	DATE OF BIRTH

HOME ADDRESS	AREA CODE	HOME PHONE	SEX
			☐ M ☐ F

CITY	STATE	ZIP CODE	AREA CODE	BUSINESS PHONE	DENTAL FACILITY #

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	EMAIL ADDRESS
EASTERN FINANCIAL FLORIDA CREDIT UNION	

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	DENTAL FACILITY #	FIRST	M.I.	LAST	SEX	BIRTHDATE
2. SPOUSE:					☐ M ☐ F	/ /
3. CHILD:					☐ M ☐ F	/ /
4. CHILD:					☐ M ☐ F	/ /
5. CHILD:					☐ M ☐ F	/ /

EFFECTIVE DATE	GROUP CODE #	15391	AGENT CODE	0103023 FL

I wish to enroll in the Prepaid Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

Applicant's Signature: **X** _____ Date _____

SEL-15AP

Schedule of Benefits and Surcharges

Select 15 FLORIDA

PROCEDURE		PATIENT PAYS
APPOINTMENTS		
9430	Office visit (normal hours)	5.00
9430	Emergency Visit (regular hours)	20.00
9440	Emergency Visit (after hours)	35.00
0999	Broken appointments (without 24 hours notice/ per 15 min.) Maximum $40.00 per broken appointment. No charge will be made due to emergencies.	10.00
DIAGNOSTIC		
0140/0150/0160	Oral evaluation	**NO CHARGE**
0120	Periodic oral evaluation	**NO CHARGE**
0470	Diagnostic casts (study models)	**NO CHARGE**
0999	Diagnosis and treatment plan presentation	**NO CHARGE**
9310	Consultation (second opinion) as provided by participating dentist	10.00
0460	Pulp vitality tests	**NO CHARGE**
RADIOGRAPHS (x-rays)		
0210	Intraoral-complete series	**NO CHARGE**
0220	Intraoral-periapical – first film	**NO CHARGE**
0230	Intraoral-periapical – each additional film	**NO CHARGE**
0270	Bitewing – single film	**NO CHARGE**
0272	Bitewing – two films	**NO CHARGE**
0274	Bitewing – four films	**NO CHARGE**
0330	Panoramic	**NO CHARGE**
PREVENTIVE		
1110/1120	Prophylaxis (routiune, once every 6 months)	**NO CHARGE**
1110/1120	Additional prophylaxis	15.00
1201/1203	Topical application of fluoride (up to 16 years of age)	**NO CHARGE**
1351	Sealant-per tooth	7.00
1330	Oral hygiene instruction	**NO CHARGE**
SPACE MAINTAINERS		
1510	Fixed, unilateral	*45.00
1515	Fixed, bilateral	*45.00
1520	Removable, unilateral	*85.00
1525	Removable, bilateral	*85.00
1550	Recementation of space maintainer	10.00
RESTORATIVE (fillings)		
2999	Sedative base (under fillings)	**NO CHARGE**
Amalgam (silver):		
2110/2140	One surface	**NO CHARGE**
2120/2150	Two surfaces	**NO CHARGE**
2130/2160	Three surfaces	**NO CHARGE**
2131/2161	Four or more surfaces	**NO CHARGE**
Resin restoration (including acid etch, glass ionomer liner)		
2330	Anterior one surface	30.00
2331	Anterior two surfaces	37.00
2332	Anterior three surfaces	45.00
2510	Inlay-metallic – one surface	85.00
2520	Inlay-metallic – two surfaces	95.00
2530	Inlay-metallic – three surfaces	120.00
2940	Sedative filling	15.00
CROWN & BRIDGE		
2930	Prefabricated stainless steel – primary tooth	45.00
2790/2791/2792/6790/6791/6792	Full cast crown	220.00
2750/2751/2752/6750/6751/6752	Porcelain fused to metal crown	240.00
2810	Three quarter cast crown	220.00
Pontics:		
6210/6211/6212	Full cast pontic	220.00
6240/6241/6242	Porcelain fused to metal pontic	240.00
2950	Core build up	40.00
2951	Pin retention-per tooth	12.00
2952	Cast post and core	90.00
2954	Prefabricated post and core	75.00
2910/2920/6930	Recement inlay/onlay/crown/bridge (per unit)	10.00
ENDODONTICS		
3220	Therapeutic pulpotomy	30.00
Root Canals:		
3310	Anterior	100.00
3320	Bicuspid	190.00
3330	Molar	240.00
3410	Apicoectomy (anterior only)	95.00

PROCEDURE		PATIENT PAYS
PERIODONTICS (gum treatment)		
4210	Gingivectomy/gingivoplasty – per quadrant	120.00
4211	Gingivectomy/gingivoplasty – per tooth	36.00
4220	Gingival currettage, surgical – per quadrant	65.00
4341	Periodontal scaling and root planing – per quadrant	45.00
4355	Full mouth debridement	35.00
4381	Localized delivery of chemotherapeutic agents (2 teeth)	45.00
4910	Periodontal maintenance procedures	45.00
PROSTHODONTICS		
Standard complete dentures (includes adjustments within 30 days)		
5110	Complete maxillary (upper)	260.00
5120	Complete mandibular (lower)	260.00
5130	Immediate maxillary (upper)	280.00
5140	Immediate mandibular (lower)	280.00
Partial dentures (includes adjustments within 30 days)		
5211/5212	Maxillary/mandibular partiall – resin base (w/2 clasps)	280.00
5213/5214	Maxillary/mandibular partial – cast metal with resin base (w/ clasps)	350.00
5410/5411	Adjust complete – maxillary/mandibular	15.00
5421/5422	Adjust partial denture – maxillary/mandibular	15.00
5999	Additional clasps	30.00
REPAIRSTO PROSTHETICS		
5510/5610	Repair broken resin denture base	*15.00
5520/5640	Repair missing or broken teeth (each tooth)	*10.00
5520/5640	Each additional tooth	*10.00
5630	Repair or replace broken clasp	*15.00
5650	Add tooth to existing partial denture	*30.00
5850/5851	Tissue conditioning	25.00
5730/5731/5740/5741	Relining (chairside)	45.00
5750/5751/5760/5761	Relining (laboratory)	*35.00
EXTRACTIONS/ORAL SURGERY		
7110	Single tooth	**NO CHARGE**
7120	Each additional tooth (per visit)	10.00
7130	Root removal-exposed roots	10.00
7210	Surgical extraction of erupted tooth	25.00
7220	Soft tissue impaction	40.00
7230	Partial bony impaction	60.00
7240	Complete bony impaction	75.00
7250	Surgical removal of residual tooth roots	25.00
7310	Alveoloplasty in conjunction w/extractions – per quad	20.00
7320	Alveoplasty not in conjunction w/extractions – per quad	50.00
ANESTHESIA		
9215	Local anesthesia	**NO CHARGE**
9230	Analgesia (nitrous oxide) per 15 minutes	15.00
ADJUNCTIVE SERVICES		
9951	Occlusal adjustment – limited	25.00
9952	Occlusal adjustment – complete	150.00

ORTHODONTICS

Benefits for orthodontics for adults and children are available from Participating Orthodontists at their usual fee less 25%.

THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS AND SEMI-PRECIOUS METAL.

All procedures listed may not be performed by the Participating General Dentist you select. The copayments shown apply to those American Dental Plan Participating General Dentists who do perform those services and are not applicable for services performed by a specialist. Therefore, you are encouraged to discuss availability of the scheduled services with your Participating General Dentist. Procedures not listed on the schedule of benefits, that are performed by the selected Participating General Dentist will be charged at the Participating General Dentist's usual and customary fee less 25%.

SPECIALISTS

Should you need a specialist (i.e. Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist from our directory. Upon identification of yourself as an American Dental Plan member, you will receive a 25% reduction from usual and customary fees for services performed. Specialist services are available only in areas where American Dental Plan has a Participating Specialist.

NOTE:

When crown and/or bridgework exceeds six consecutive units, the patient may be charged an additional $25.00 per unit.

*Plus laboratory fees when applicable.

FL/S15/06/03
6-03

AUTHORIZATION FOR DEDUCTION - Signature Required

Name _____

(Last) (First) (MI)

I authorize THE CREDIT UNION to make a monthly deduction of $ _____

- ☐ Member ..... $ 12.78
- ☐ Member + 1 dependent ..... $ 24.26
- ☐ Member + 2 or more dependent..... $ 32.40

☐ Checking ☐ Savings Account # _____ RT #267080177 and to remit the amount deducted to **CompBenefits (CB).** The amount of deduction indicated above is approximate and may be corrected as instructed by **CB.** This authorization shall cease (a) upon my giving written cancellation notice to you; (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization; (c) automatically upon termination of my checking, savings or share account numbered above as this authorization related to such an account or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and **CB.** I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CB** and if this authorization terminates for any reason, any further payments required under said policy(s) shall be made as provided in the policy(s). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CB.**

Date _____ 20 _____ Signature X _____