Group Benefit Page

Name of Group: Transport Workers Union Local 100

Group Number: GG-668P01 (PPO - Reimbursement Plan)
GG-668M01 (Managed Care - Comprehensive Plan)

Effective Date: September 1, 2014

Plan Number: 111M111ZV0 (PPO - Reimbursement)

Benefit Period: Calendar Year

Reimbursement Plan – Covered services can be rendered by any dentist. To use the plan, members should be treated by the dentist of their choice and submit claims to Dentcare Delivery Systems, Inc. (Dentcare). Payments by the plan are subject to the following terms:

Individual Deductible: N/A

Family Deductible: N/A

Coinsurance Percentages:

Category I	Diagnostic Services Preventive Services	100 %	of the maximum allowable amount.
Category II	Basic Restorative Services Endodontic Services Periodontal Services Oral Surgery Services	100 %	of the maximum allowable amount.
Category III	Major Restorative Services Prosthetic Services	100 %	of the maximum allowable amount.
Category IV	Orthodontic Services	100 %	of the maximum allowable amount.

Individual Maximum (Category I, II, III):	$1,800.00**	per benefit period
Family Maximum (Category I, II, III):	$3,600.00**	per benefit period
Orthodontic Maximum (Category IV):	$1,740.00	Lifetime

***Annual Maximum only applies to members/dependents who are age 19 or older.*

Managed Care Plan - Covered services can only be rendered by participating dentists. Each covered person must select one participating dentist (per family) to provide general dental services. These general dentists will provide all covered services according to the Schedule of Copayments. Many services will be provided at no cost. Others may have small copayments that patients will pay directly to the dentist. When endodontic, periodontal, surgical or orthodontic treatment is needed by a specialist, the participating general dentist will refer the case to participating specialists. Unless otherwise noted, patient copayments will be the same when services are rendered by participating specialists. In the event that participating specialists are not available within 50 miles of your participating general dentist, you may be entitled to receive a benefit equal to the amount that we would pay a participating specialist. Members have no benefits when treatment is provided by a non-participating general dentist or when specialty services are provided without a referral from Dentcare or the participating general dentist.

Dependent Eligibility – Dependent Children are covered up to their 19th birthday, or up to their 23rd birthday if a full-time student.

Orthodontics – Dependent Children only.

Transport Workers Union Local 100
GG-668P01 / GG-668M01

Managed Care: Comprehensive Plan (GG-668M01): These fees are the most you will pay to your Dentcare participating Managed Care dentist for services listed.

PPO: Out-of-Network Reimbursement (GG-668P01): The reimbursement allowances are the most that your plan will pay for the services listed. You are responsible to your dentist for any additional cost.

PPO: In-Network PPO Copayments (GG-668P01): If you receive covered treatment from an In-Network PPO provider, your costs are limited to the amounts shown.

	GG-668M01 Managed Care Copayments	GG-668P01 PPO Out-of-Network Reimbursement	GG-668P01 PPO In-Network PPO Copayments
Diagnostic & Preventive Services			
Periodic Oral Examination	No Charge	$10.00	No Charge
Full Mouth X-Rays	No Charge	20.00	No Charge
Single Films (Periapical or Bitewing)	No Charge	2.00/2.50	No Charge
Bitewings, 2 Films/4 Films	No Charge	5.00/10.00	No Charge
Prophylaxis, Adult/Child	No Charge	10.00/7.00	No Charge
Fluoride Treatment	No Charge	10.00	No Charge
Space Maintainers, Fixed/Removable	No Charge	50.00/40.00	No Charge
Specialty Consultation	No Charge	20.00	No Charge
Emergency Treatment	No Charge	15.00	No Charge
Restorative			
Amalgam, one surface/two surfaces/three surfaces	No Charge	10.00/20.00/25.00	No Charge
Anterior Composite Filling, one surface/two surfaces/three surfaces*	No Charge	15.00/25.00/30.00	No Charge
Oral Surgery			
Routine/Surgical Extractions	No Charge	10.00/30.00	No Charge
Soft Tissue Impactions	No Charge	30.00	No Charge
Bony Impactions (Partial/Full)	No Charge	50.00/90.00	No Charge
Alveolectomy, per quadrant w/extraction	No Charge	50.00	No Charge
Biopsy, Hard/Soft Tissue	No Charge	20.00	No Charge
Root Canal Therapy			
Pulp Capping, Direct/Indirect	No Charge	8.00	No Charge
Root Canal Therapy, Anterior	No Charge	75.00	No Charge
Root Canal Therapy, Bicuspid	No Charge	100.00	No Charge
Root Canal Therapy, Molar	No Charge	150.00	No Charge
Apicoectomy (Anterior/Molar)	No Charge	70.00	No Charge
Periodontics			
Scaling of Teeth, per quad	No Charge	20.00	No Charge
Gingivectomy, per quad	No Charge	65.00	No Charge
Osseous Surgery, per quad	No Charge	65.00	No Charge
Prosthetics – Crowns			
Acrylic w/Metal Crown	No Charge	125.00	No Charge
Porcelain Crown	No Charge	175.00	No Charge
Porcelain w/Metal Crown	No Charge	170.00	No Charge
Full Cast Metal Crown	No Charge	110.00	No Charge
Stainless Steel Crown	No Charge	40.00	No Charge
Cast Post and Core	No Charge	35.00	No Charge
Recementation, per crown	No Charge	8.00	No Charge
Prosthetics – Fixed Bridges			
Porcelain w/Metal Bridge Crown/Pontic	No Charge	175.00/100.00	No Charge
Full Cast Metal Bridge Crown	No Charge	125.00	No Charge
Recementation, bridge	No Charge	25.00	No Charge
Prosthetics Removable			
Full Upper or Lower Denture, w/adjustments	No Charge	200.00	No Charge
Partial Upper or Lower Denture, Cast Base/Resin	No Charge	225.00/150.00	No Charge
Prosthetics Repairs			
Broken Body of Denture	No Charge	15.00	No Charge
Add Tooth to Partial Denture	No Charge	30.00	No Charge
Replacement of Broken/Missing Teeth	No Charge	5.00	No Charge
Reline – Complete Upper or Lower Denture Office/Lab	No Charge	30.00/50.00	No Charge
Reline – Partial Upper or Lower Denture Office/Lab	No Charge	30.00/50.00	No Charge
Orthodontics			
Maximum Case Fee – 24 months	No Charge		No Charge
Lifetime Maximum – 24 months (Initial Insertion $300.00. Monthly Adjustment $60.00)		$1,740.00	

**Composite Fillings (Tooth-Colored Fillings): one per tooth surface per 12 month period (on anterior and bicuspid teeth only). Composites on molars are considered cosmetic.*

This fee schedule contains a general description of your dental care program for your use as a convenient reference. **Due to certain Exclusions and/or Limitations, all member copayments may not be applicable**. Prior to receiving any treatment, please obtain the Certificate of Insurance from your benefit administrator for Exclusions and Limitations. A copy of your Certificate of Insurance may also be obtained from our website at www.healthplex.com. All benefits are governed by the provisions of your group's contract.