# Group Benefit Page

**Name of Group:** Transport Workers Union Local 100
**Group Number:** 1735484 (64009)
**Plan Type:** PPO
**Plan Effective Date:** October 1, 2020
**Benefit Period:** Calendar Year

**Plan Description –** Covered services can be rendered by any licensed dentist. To use the plan, members should be treated by the dentist of their choice and submit claims to Dentcare. Using an in-network PPO provider may eliminate or reduce the member's out-of-pocket expense. Additional information can be found on the reverse side.

**Payments by the plan are subject to the following terms**

| | | |
|---|---|---|
| **Category I** | Diagnostic Services<br>Preventive Services | 100 % of the maximum allowable amount |
| **Category II** | Basic Restorative Services<br>Endodontic Services<br>Periodontal Services<br>Oral Surgery Services<br>Prosthetic Repair/Reline Services<br>Adjunctive Services | 100 % of the maximum allowable amount |
| **Category III** | Major Restorative Services<br>Prosthetic Services<br>Implant Services | 100 % of the maximum allowable amount |
| **Category IV** | Orthodontic Services | 100 % of the maximum allowable amount |

| | | |
|---|---|---|
| **Individual/Family Deductible:** | N/A | |
| **Individual Maximum (Category I, II, III):** | $1,800.00* | per benefit period |
| **Family Maximum (Category I, II, III):** | $3,600.00 | per benefit period |
| **Implant Maximum:** | $1,000.00 | per benefit period |
| **Localized Delivery of Antimicrobial Agents:** | $100.00 | per lifetime |
| **Orthodontic Maximum (Category IV):** | $2,195.00<br>$1,800.00 | per lifetime in-network<br>per lifetime out-of-network |

**Individual annual maximum does not apply to dependent children up to their 19th birthday.*

**Dependent Eligibility –** Dependent children are covered up to their 26th birthday.

**Orthodontics –** Dependent children must be fully banded prior to their 23rd birthday to have coverage up to age 26. Lifetime orthodontic maximum includes initial banding and up to 24 monthly adjustments for class I, II and III cases. Coverage for two retainers (one per arch) is included in the individual/family annual maximum.

**Note:** **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 an explanation of these Exclusions and Limitations. A copy of your Certificate of Insurance may also be obtained from our website at yourdentalplan.com/healthplex All benefits are governed by the provisions of your group's contract.

As of January 1st, 2024 your new group number is **1735484** and your new portal is **yourdentalplan.com/healthplex**

# Schedule of Benefits

Transport Workers Union Local 100
1735484 (64009) - PPO

| Services | In-Network PPO Copayments | Out-of-Network Reimbursement |
|---|---|---|
| **Diagnostic & Preventive** | | |
| Periodic Oral Examination | No Charge | $10.00 |
| X-Rays, Complete Series | No Charge | 20.00 |
| Periapical, First Film | No Charge | 2.00 |
| Bitewings, Four Films | No Charge | 10.00 |
| Prophylaxis, Adult/Child | No Charge | 10.00/7.00 |
| Fluoride Treatment | No Charge | 10.00 |
| Sealants, Per Tooth | No Charge | 8.00 |
| Space Maintainer, Fixed/Removable | No Charge | 50.00/40.00 |
| **Basic Restorative** | | |
| Amalgam, One/Two/Three/Four+ Surfaces | No Charge | 10.00/20.00/25.00/25.00 |
| Composite, One/Two/Three/Four+ Surfaces | No Charge | 15.00/25.00/30.00/35.00 |
| **Endodontics** | | |
| Pulp Cap, Direct/Indirect | No Charge | 8.00 |
| Root Canal Therapy, Anterior/Bicuspid/ Molar | No Charge | 75.00/100.00/150.00 |
| Apicoectomy, Anterior/Molar | No Charge | 70.00 |
| **Periodontics** | | |
| Gingivectomy, Per Quad | No Charge | 65.00 |
| Osseous Surgery, Per Quad | No Charge | 65.00 |
| Crown Lengthening | No Charge | 65.00 |
| Scaling & Root Planing, Per Quad | No Charge | 20.00 |
| Localized Delivery of Antimicrobial Agents | No Charge | 60.00 |
| Periodontal Maintenance | No Charge | 15.00 |
| **Oral Surgery** | | |
| Routine/Surgical Extraction | No Charge | 10.00/30.00 |
| Soft Tissue Impaction | No Charge | 30.00 |
| Partial/Full Bony Impaction | No Charge | 50.00/90.00 |
| Biopsy, Hard/Soft Tissue | No Charge | 20.00 |
| **Major Restorative** | | |
| Porcelain with High Noble Metal Crown | No Charge | 170.00 |
| Full Cast High Noble Metal Crown | No Charge | 110.00 |
| Re-cement Crown | No Charge | 8.00 |
| Post and Core | No Charge | 35.00 |
| **Prosthetics - Removable** | | |
| Complete Upper/Lower Denture | No Charge | 200.00 |
| Partial Upper/Lower Denture, Cast Base | No Charge | 225.00 |
| **Prosthetic - Fixed Bridges** | | |
| Porcelain with High Noble Metal Pontic/Abutment | No Charge | 100.00/175.00 |
| Full Cast High Noble Metal Abutment | No Charge | 125.00 |
| Re-cement Bridge | No Charge | 25.00 |
| **Implant Services**** | | |
| Endosteal Implant | No Charge | 1,000.00 |
| Prefabricated/Custom Fabricated Abutment | No Charge | 550.00/650.00 |
| Abutment Supported Porcelain High Noble Metal Crown | No Charge | 1,000.00 |
| Implant Supported Porcelain/Ceramic Crown | No Charge | 1,000.00 |
| Bone Graft at Time of Implant Placement | $100.00 | 200.00 |
| **Prosthetic Repairs/Relines** | | |
| Repair Complete Denture Broken Base | No Charge | 15.00 |
| Repair Partial Denture Base/Framework | No Charge | 15.00/18.00 |
| Add Tooth/Clasp to Existing Partial Denture | No Charge | 30.00/35.00 |
| Replace Complete/Partial Denture Broken Tooth | No Charge | 5.00/15.00 |
| Reline Denture - Direct/Indirect | No Charge | 30.00/50.00 |
| **Adjunctive Services** | | |
| Palliative Treatment | No Charge | 15.00 |
| Anesthesia (15 minutes) | No Charge | 4.00 |
| Occlusal Guard | $300.00 | Not Covered |

## In-Network PPO Copayments

You may select any dentist from the Metro Directory of Participating Providers. Some services are rendered without any cost while others may have a minimal copayment you pay directly to the dentist.

## Out-of-Network Reimbursement

When services are rendered by a non-participating provider, you will be reimbursed up to the Out-of-Network Reimbursement allowance indicated in the *Schedule of Benefits*. You will be responsible for all costs exceeding that amount.

## **Implant Services

These services are included in a separate $1,000 annual implant maximum. Once the $1,000 implant maximum has been reached in-network, the member will be responsible for 100% reduced fees for implant or implant related services performed by an in-network PPO provider.

## Treatment Options/Materials

Due to the element of choice involved in the utilization of many dental services, situations arise where two or more methods of treatment for a particular dental condition could be used, each of which may produce a desirable professional result. Please speak with your dentist regarding the options covered under your dental plan.

**Note:** The *Schedule of Benefits* contains a partial listing of the most frequently utilized services covered under this plan. Frequencies and limitations apply.

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