Group Benefit Page

Name of Group: Local 72 Welfare Fund - New York Thruway

Group Number: GG-258

Effective Date: August 1, 1996

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 Healthplex. 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 Preventive Services	100%	of the maximum allowable amount
Category II	Basic Restorative Services Endodontic Services Periodontal Services Oral Surgery Services Adjunctive 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/Family Deductible:		N/A	
X-Ray Maximum:		$136.00	per benefit period
Individual/Family Maximum (Category I, II, III):		N/A	
Implant Maximum:		$10,000.00	per benefit period

Dependent Eligibility: Dependent children are covered up to their 19th birthday, or up to their 25th birthday if a full time student.

Orthodontics: Coverage is based on a 24-month case and includes the initial banding and monthly adjustments for dependent children and adults. Pre-certification is required prior to receiving orthodontic treatment and will help determine your out-of-pocket expense. Your copayments may vary based on the provider seen at the time of care.

Implants: Implants and related services are covered and included in a $10,000 additional annual maximum. Pre-certification is required prior to receiving treatment and will help determine your out-of-pocket expense for implant services. Your copayments may vary based on the provider seen at the time of care.

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In-Network PPO Copayments

You may select any dentist from the National Plus Directory of Participating Providers. Some services are rendered without any cost, while others 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.

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. All benefits are governed by the provisions of your group's contract. Frequencies and limitations apply.

Schedule of Benefits

Diagnostic & Preventive	In-Network PPO Copayments	Out-of-Network Reimbursement
Periodic Oral Examination	No Charge	$22.00
X-Rays, Complete Series	No Charge	56.00
Periapical, First Film	No Charge	10.00
Bitewings, Four Films	No Charge	21.00
Prophylaxis, Adult/Child	No Charge	44.00/30.00
Fluoride Treatment	No Charge	31.00
Sealants, Per Tooth	No Charge	30.00
Basic Restorative		
Amalgam, 1/2 Surfaces	No Charge	$45.00/60.00
Amalgam, 3/4+ Surfaces	No Charge	75.00/85.00
Composite, 1 Surface, Anterior/Posterior	No Charge	50.00
Composite, 2 Surfaces, Anterior/Posterior	No Charge	70.00
Composite, 3 Surfaces, Anterior/Posterior	No Charge	88.00/81.00
Composite, 4+ Surfaces, Anterior/Posterior	No Charge	95.00
Re-cement Crown	No Charge	38.00
Re-cement Bridge	No Charge	62.00
Endodontics		
Root Canal Therapy, Anterior	No Charge	$350.00
Root Canal Therapy, Bicuspid	No Charge	425.00
Root Canal Therapy, Molar	75.00	425.00
Apicoectomy, Anterior	No Charge	210.00
Periodontics		
Gingivectomy, Per Quad	No Charge	$180.00
Osseous Surgery, Per Quad	No Charge	460.00
Periodontal Maintenance	No Charge	72.50
Scaling & Root Planing, Per Quad	No Charge	90.00
Oral Surgery		
Routine/Surgical Extraction	No Charge	$66.00/110.00
Soft Tissue Impaction	No Charge	155.00
Partial/Full Bony Impaction	No Charge	188.00/240.00
Major Restorative		
Porcelain with High Noble Metal Crown	$100.00	$495.00
Full Cast High Noble Metal Crown	100.00	425.00
Post and Core, Cast/Prefabricated	No Charge	165.00/105.00
Prosthetics - Removable		
Complete Upper/Lower Denture	$100.00	$550.00
Partial Upper/Lower Denture, Cast Base	100.00	595.00
Prosthetics - Fixed		
Porcelain with High Noble Metal Pontic/Abutment	$100.00	$495.00
Full Cast High Noble Metal Abutment	100.00	425.00
Prosthetic Repairs/Relines		
Repair Complete Denture Broken Base	No Charge	$65.00
Repair Partial Denture Base/Framework	No Charge	65.00/100.00
Replace Complete/Partial Denture Broken Tooth	No Charge	65.00/55.00
Add Tooth/Clasp to Existing Partial Denture	No Charge	55.00/90.00
Reline Complete Upper/Lowe Denture - Chair	No Charge	135.00
Reline Complete Upper/Lower Denture - Laboratory	No Charge	150.00/200.00
Adjunctive Services		
Palliative Treatment	No Charge	$30.00
Anesthesia (15 minutes)	No Charge	56.67

Administered by

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