

ADMINISTRATIVE SERVICES ONLY PLAN SUMMARY

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

Group Number: GG-258

Effective Date: January 1, 2015

Plan Number: N/A

Benefit Period: Calendar Year

Reimbursement Plan – Covered services can be rendered by any dentist. To use this plan, members should be treated by the dentist of their choice and submit claims to Healthplex. 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	<u> 100 </u> %	of the maximum allowable amount.
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Category II	Basic Restorative Services Endodontic Services Periodontal Services Oral Surgery Services	<u> 100 </u> %	of the maximum allowable amount.
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Category III	Major Restorative Services Prosthetic Services	<u> 100 </u> %	of the maximum allowable amount.
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Category IV	Orthodontic Services	<u> 100 </u> %	of the maximum allowable amount.
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X-Ray Maximum:	<u> \$67.00 </u>	per 24 month period
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Implant Maximum:	<u> \$800.00 </u>	per benefit period*
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Individual Maximum (Category I, II, III):	<u> N/A </u>	per benefit period
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Family Maximum (Category I, II, III):	<u> N/A </u>	per benefit period
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Orthodontic Maximum (Category IV):	<u> \$4,000.00 </u>	per benefit period
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** Member, spouse and eligible dependents 21 years of age and older are eligible to receive an \$800 annual reimbursement for any implant or implant related service. Member is responsible to pay the provider's fee in full, and then submit a claim for reimbursement.*

Dependent Eligibility – Dependent Children are covered up to their 19th birthday, or up to their 25th birthday if a full-time student.

Orthodontics – Dependent Children and Adults.

NEW YORK THRUWAY - LOCAL 72 WELFARE FUND MEMBER REIMBURSEMENT SCHEDULE - GG-258

Category	Services	Out-of-Network Reimbursement	In-Network PPO Copayments
Diagnostic & Preventive	Periodic Oral Examination	\$22.00	No Charge
	Full Mouth Series X-Rays	56.00	No Charge
	Periapical, First Film	10.00	No Charge
	Bitewings, Four Films	21.00	No Charge
	Prophylaxis, Adult/Child	44.00/30.00	No Charge
	Fluoride Treatment	31.00	No Charge
	Sealants, Per Tooth	30.00	No Charge
Basic	Amalgam, 1 Surface	45.00	No Charge
	Amalgam, 2 Surfaces	60.00	No Charge
	Amalgam, 3 Surfaces	75.00	No Charge
	Amalgam, 4+ Surfaces	85.00	No Charge
	Resin-Based Composite, 1 Surface, Anterior	50.00	No Charge
	Resin-Based Composite, 2 Surfaces, Anterior	70.00	No Charge
	Resin-Based Composite, 3 Surfaces, Anterior	88.00	No Charge
	Resin-Based Composite, 4+ Surfaces, Anterior	95.00	No Charge
	Pulpotomy	65.00	No Charge
	Root Canal Therapy, Anterior	350.00	No Charge
	Root Canal Therapy, Bicuspid	425.00	No Charge
	Root Canal Therapy, Molar	425.00	\$75.00
	Apicoectomy, Anterior	210.00	No Charge
	Gingivectomy, Per Quad	180.00	No Charge
	Osseous Surgery, Per Quad	460.00	No Charge
	Scaling/Root Planing, Per Quad	90.00	No Charge
	Routine/Surgical Extraction	66.00/110.00	No Charge
	Soft Tissue Impaction	155.00	No Charge
	Partial/Full Bony Impaction	188.00/240.00	No Charge
	Alveolectomy, Per Quad, w/Extraction	62.00	No Charge
	Recementation Crown	38.00	No Charge
	Recementation Bridge	62.00	No Charge
	Palliative Treatment	30.00	No Charge
Major	Porcelain with High Noble Metal Crown	495.00	100.00
	Stainless Steel Crown (Primary Tooth)	110.00	No Charge
	Post and Core, Casted	165.00	No Charge
	Complete Upper or Lower Denture	550.00	100.00
	Partial Upper or Lower Denture, Cast Base	595.00	100.00
	Broken Body of Denture	65.00	No Charge
	Replacement of Broken/Missing Teeth	65.00	No Charge
	Porcelain with High Noble Metal Pontic	495.00	100.00
	Porcelain with High Noble Metal Abutment	495.00	100.00
Orthodontics	Maximum Case Fee - 24 Months		
	Dependent Children	\$4,000.00	No Charge
	Adult Orthodontia	\$4,000.00	\$1,650.00

Out-of-Network Reimbursement

When services are received from an Out-of-Network dentist, you will be reimbursed up to the Maximum Out-of-Network Reimbursement and you will be responsible for costs exceeding your reimbursement.

In-Network PPO Copayments

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

This fee schedule contains a general description of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract.

Administered by

