Group Benefit Page

Name of Group: United Welfare Fund

Group Number: L1AKOO213N

Effective Date: June 1, 2011

Plan Number: I (No Orthodontics)

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 Healthplex. Payments by the plan are subject to the following terms:

Individual Deductible	N/A
Family Deductible:	N/A

Coinsurance Percentages:	**Services**	**%**	**Percentage**
Category I	Diagnostic Preventive	100	of the maximum allowable amount
Category II	Basic Restorative Endodontic Periodontal Oral Surgery	100	of the maximum allowable amount
Category III	Major Restorative Prosthetic	100	of the maximum allowable amount
Category IV	Orthodontic	0	of the maximum allowable amount
Individual Maximum (Category I, II, III):		$2,000.00	per benefit period
Family Maximum (Category I, II, III):		N/A	per benefit period
Orthodontic Maximum (Category IV):		N/A	Lifetime

Dependent Eligibility: Dependent Children are covered up to the end of the month of their 26th birthday.

Orthodontics*: Dependent Children up to age 19 will recieve reduced fees available at participating orthodontic offices.

Note: The dental coverage described on this Benefit Page is subject to the provisions of the dental agreement between Healthplex Insurance Company and your group. Please refer to the Certificate of Insurance booklet for a summary of the contractual terms that affect your benefits.

healthplex

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In-Network PPO Copayments

When services are received from participating dentists in the Healthplex Liberty PPO Plan, you will only be responsible for the copayment, if any, shown.

Out-of-Network Reimbursement

The reimbursement amounts are the most Healthplex will pay for the services listed. You are responsible to your dentist for any additional cost.

Dental Implant Benefit

Below you will find covered implant services and the associated member cost. This added benefit only applies to services received from In-Network Liberty PPO providers. There is no Out-of-Network or Careington PPO Network benefit.

Description	Member Copayment
Endosteal Implant	$1,400.00
Prefabricated Abutment	550.00
Custom Fabricated Abutment	650.00
Implant Supported Porcelain/Ceramic Crown	1,200.00
Abutment Supported Porcelain Fused w/High Noble Crown	1,000.00

This fee schedule contains a general description of your dental care program for your use as a convenient reference. For Exclusions and Limitations see Certificate of Insurance. A copy of your Certificate of Insurance can be obtained from our website at healthplex.com. All benefits are governed by the provisions of your group's contract.

Administered by

Underwritten by Healthplex Insurance Company
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Diagnostic & Preventive Services	In-Network PPO Copayments	Out-of-Network Reimbursement %
Comprehensive Oral Examination	No Charge	$22.00
Periodic Oral Examination	No Charge	16.50
Full Mouth Series X-Rays	No Charge	49.50
Periapical, First Film	No Charge	8.80
Bitewing, Four Films	No Charge	18.70
Prophylaxis, Adult/ Child	No Charge	38.50/22.00
Fluoride Treatment	No Charge	27.50
Sealant, Per Tooth	No Charge	22.00

Basic		
Amalgam, 1 Surface	No Charge	$38.50
Amalgam, 2 Surfaces	No Charge	49.50
Amalgam, 3 Surfaces	No Charge	60.50
Amalgam, 4+ Surfaces	No Charge	71.50
Resin-Based Composite, 1 Surface, Anterior	No Charge	44.00
Resin-Based Composite, 2 Surfaces, Anterior	No Charge	60.50
Resin-Based Composite, 3 Surfaces, Anterior	No Charge	77.00
Resin-Based Composite, 4+ Surfaces, Anterior	No Charge	77.00
Pulpotomy	No Charge	49.50
Root Canal Therapy, Anterior	No Charge	275.00
Root Canal Therapy, Bicuspid	No Charge	330.00
Root Canal Therapy, Molar	No Charge	412.50
Apicoectomy, Anterior	No Charge	192.50
Gingivectomy, Per Quad	No Charge	165.00
Osseous Surgery, Per Quad	No Charge	412.50
Scaling/Root Planing, Per Quad	No Charge	82.50
Routine Extraction	No Charge	60.50
Surgical Extraction	No Charge	93.50
Soft Tissue Impaction	No Charge	137.50
Partial Bony Impaction	No Charge	165.00
Full Bony Impaction	No Charge	214.50
Alveolectomy, Per Quad, w/Extraction	No Charge	55.00
Recementation Crown/Bridge	No Charge	27.50/55.00
Stainless Steel Crown (Primary Tooth)	No Charge	99.00
Post and Core, Casted	No Charge	148.50
Palliative Treatment	No Charge	27.50

Major		
Porcelain with Metal Crown	No Charge	467.50
Complete Upper or Lower Denture	No Charge	577.50
Partial Upper or Lower Denture, Cast Base	No Charge	632.50
Broken Body of Denture	No Charge	49.50
Replacement of Broken/Missing Teeth	No Charge	49.50
Porcelain with Metal Pontic	No Charge	467.50
Porcelain with Metal Abutment	No Charge	467.50

Orthodontics		
Maximum Case Fee - 24 Months	**$2,740.00**	**Not Covered**

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