TEAMSTERS BENEFIT TRUST

COMPARISON OF DENTAL BENEFITS

JULY 2023

Comparison of Dental Benefits—Plan IV

Read this ***Comparison of Dental Benefits*** *to choose your dental option when filling out your* ***TBT Dental Option Form****. The dental option you select must be the same for you and your covered dependents.*

This is a summary of dental benefits offered by each TBT dental option. For a more complete description of benefits through Option 1—the Indemnity Dental option, read the *Guide to Your Benefits* and *Summary of Coverage*. To request brochures for Option 2 or Option 3, the prepaid dental options, contact the TBT Plan Administration Office (listed on last page).

Coverage begins for you and your covered dependents only after you choose a dental option by returning your *Dental Option Form*. Please read your enrollment materials and return your *Dental Option Form* without delay. Do not schedule dental services until you are sure your coverage is effective.

New employees may only choose Option 2 or Option 3 until a waiting period is satisfied. Option 1 (the Indemnity Dental option) is not available until one year following your initial hire date (unless you meet an exception listed on the back of your *Dental Option Form*).

You can change your TBT medical and dental options once a year. TBT's Open Enrollment takes place from January 1 through December 31. After your initial election of medical and dental options, you may change them once every 12 months. Some restrictions apply—so be sure to check the dental section of the *Guide to Your Benefits*. If you have questions about eligibility or benefits, call the TBT Plan Administration Office.

Benefits	SELF-FUNDED OPTION Option 1 Indemnity Dental (Delta Dental)	PRE-PAID DENTAL OPTIONS Option 2 Bright Now! Dental	PRE-PAID DENTAL OPTIONS Option 3 United Healthcare Dental
Choice of Dentist	You may choose any dentist, but your out-of-pocket expenses are less if you choose Delta dentists.	You must choose a *Bright Now!* Dental dentist.	You must choose a United Healthcare Dental dentist.
Pre-Authorization of Expenses	Pre-treatment estimate required for covered services of $500 or more—some or all expenses are not paid.	Covered services must be prescribed or authorized by *Bright Now!* Dental dentist.	Covered services must be prescribed or authorized by United Healthcare Dental dentist.
Deductible	None	None	None
Calendar Year Maximum	$2,200 per covered person	None	None
Preventive Care *Oral exam* *Cleanings* *Fluoride care* *Extra exam/cleaning during pregnancy* *X-rays*	Payable twice per calendar year: If Delta dentist, 70% of all charges; if non-Delta dentist, 70% of Usual, Customary & Reasonable (UCR) charges.	100% paid; cleanings provided once in six months.	100% paid; cleanings provided once in six months.
Basic Care *Tooth extractions* *Oral surgery* *Fillings* *Endodontic* *Anesthesia* *Periodontics*	Paid at 70% if Delta dentist; if non-Delta dentist, 70% of UCR charges.	100% for covered services.	100% for covered services.
Major Care *Crowns & bridges* *Gold fillings* *Gold inlays/onlays* *Dentures* *Prosthodontic benefits*	Paid at 70% if Delta dentist; if non-Delta dentist, 70% of UCR charges.	100% for covered services; limits on some services.	100% for covered services; limits on some services.
Orthodontia	Not covered	Copayment of $1,800 to age 19; $2,450 age 19 and older (full-banded two-year case).	Copayment of $1,800 to age 19; $2,450 age 19 and older (full-banded two-year case) plus start-up fees maximum of $350.
Copayments	Payable by you for amounts not covered.	None except as noted for orthodontia.	None except as noted for orthodontia; $25 charge for no-shows or after-hours visits.
Claim Forms	None unless non-Delta dentist	No claim forms	No claim forms
Appeals	Contact Delta Dental at (800) 765-6003 or (888) 335-8227. If not resolved, refer to *Guide to Your Benefits* for appeals procedure.	Contact *Bright Now!* Dental at (714) 668-1300. If not resolved, refer to *Guide to Your Benefits* for appeals procedure.	Contact United Healthcare Dental at (800) 445-9090. If not resolved, refer to *Guide to Your Benefits* for appeals procedure.

OPTION 1—INDEMNITY DENTAL

Services Not Covered

The Indemnity Dental option covers a wide variety of dental care services, but certain expenses are not covered. For your convenience, a list of limitations and exclusions is shown below. Check the Delta Dental *Evidence of Coverage*, the *Guide to Your Benefits* and *Summary of Coverage* for any special rules or exceptions not mentioned below.

Limitations

1. Oral examinations—No more than two oral examinations per calendar year, including office visits for examinations and specialist consultations (or a combination).
2. Prophylaxis—No more than two prophylaxis visits in a calendar year, including fluoride treatments or procedures that include cleanings.
3. Bitewing x-rays—Provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults 18 and older. Full-mouth x-rays are provided once in a five-year period.
4. Oral/facial photographic images—Covered once per 36 months and diagnostic casts are covered once per lifetime in conjunction with orthodontic services. 3D x-rays are not a covered benefit. Cone beam CT image capture is a benefit limited to once in a 60-month period.
5. Sealant benefits—Include the application of sealants only to permanent first molars through age 8 and second molars through age 15 if teeth are without caries (decay) or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.
6. Crowns, jackets and cast restorations—Covered for the same tooth only once every five years.
7. Inlays/Onlays—Limited to participants 12 and older and covered no more than once in any 60-month period.
8. Prosthodontic devices such as implants—Covered only once every five years, and only if there has been such an extensive loss of remaining teeth, or a change in supporting tissues, that the existing appliance cannot be made satisfactory. For a standard cast chrome or acrylic partial denture or a standard complete denture, the Plan pays its copayment percentage of the dentist's fee allowance. Space maintainers are limited to children younger than age 13. However, a distal shoe space maintainer-fixed-unilateral is limited to children 8 and younger.
9. Periodontal limitations: a) Benefits for periodontal surgery, scaling and root planing in the same quadrant are limited to once in every 24-month period for participants 15 and older. See *Evidence of Coverage* for additional benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service. b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing performed within 24 months.
10. Treatment of temporomandibular joint dysfunction (TMJ) must be authorized in advance and is limited to a lifetime maximum of $1,000 after your copayment percentages are met. Covered expenses are paid at your Plan's copayment percentage of Delta Dental rates or UCR charges if non-Delta dentist. Covered expenses are payable at your Plan's copayment percentage for temporary repositioning appliance, occlusal guard, occlusal adjustment (complete) or removable metal overlay stabilizing appliance. Benefits are pre-approved based upon the treating dentist's documentation of the treatment plan and the need for the proposed treatment as determined by the Plan.
11. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

Exclusions

1. Treatment before the patient was eligible for Plan benefits or after coverage terminates.
2. Charges higher than those considered by the Plan to be Usual, Customary and Reasonable (UCR).
3. Treatment that is not provided by a legally qualified dentist, except for services within the scope of a dental hygienist's license under a dentist's supervision.
4. Treatment for injuries covered by Workers' Compensation or employer liability laws, or services that are paid by any federal, state or local government agency, except Medi-Cal benefits.
5. Dental treatment for cosmetic purposes (unless the expense is necessary to repair damage from an accident only if such dental treatment takes place no later than two years from the date of the accident and while still eligible).
6. Replacement of a crown, bridge or denture for which benefits were already paid by TBT within the past five years, unless the replacement of the crown, bridge or denture is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or if the device is a stay plate or similar temporary partial bridgework and is being replaced by a permanent device; or the prosthesis is damaged beyond repair as a result of injury while in the mouth.
7. Expenses for facings on crowns or pontics posterior to the second bicuspid.
8. Temporary or permanent replacement of an existing prosthodontic device that could be made satisfactory.
9. If orthodontic treatment begins before the covered person becomes eligible for coverage, benefit payments start with the first payment following your eligibility date. Plan payments stop with the first payment due following a loss of eligibility, or when treatment is ended for any reason before it is completed. **Note:** Delta Dental does not pay for repair or replacement of any orthodontic appliance furnished, in whole or in part, under this Plan.
10. Medical treatment for conditions caused directly (and independently of all other causes) by external, violent and accidental means. Such conditions may be covered under your TBT medical option (see information in the *Guide to Your Benefits*).
11. Treatment for conditions that are the result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
12. Treatment which (1) restores tooth structure that is worn, (2) rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion, or (3) stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
13. Prescribed drugs (see Your Prescription Drug Benefits in the *Guide to Your Benefits*).
14. Hospital costs and any other fees charged by a dentist for hospital treatment.
15. Experimental procedures.
16. Anesthesia, except for general anesthesia or I.V. sedation given by a licensed dentist for oral surgery services and select endodontic and periodontic procedures. Medically Necessary anesthesia for pediatric dentistry is covered under the Medical benefit.
17. Grafting tissues from outside the mouth to tissue inside the mouth (extraoral grafts).
18. Fees for specialized techniques involving precision dentures, personalizing or characterization.
19. Dietary planning.
20. Training in oral hygiene or preventive dental care.
21. Treatment for services or oral surgeries that are covered under your TBT medical option.
22. Hypnosis.
23. Charges for failure to keep scheduled appointments.
24. Expenses for which there is no legal obligation to pay.
25. Adjustments or relining of a crown, bridge or denture within six months after it was first provided. This includes any supplies provided in connection with such procedure, except that x-rays and regular cleanings are not considered to be part of the dental procedure.
26. Replacement of a crown, bridge or dentures that are lost or stolen.
27. Treatment other than full dentures that are needed solely to change the vertical dimension of teeth.
28. Treatment for conditions or services otherwise limited or excluded by the Plan.

OPTION 2—BRIGHT NOW! DENTAL

Services Not Covered

The *Bright Now!* Dental option covers a wide variety of dental care services, but certain expenses are not covered. For your convenience, a list of limitations and exclusions is shown below. Not all *Bright Now!* Dental limitations and exclusions are included here. Check the *Bright Now!* Dental brochures.

Limitations

1. Prophylaxis—One cleaning in any six consecutive months.
2. Full mouth x-rays—Once every three years unless required more often for specific diagnostic treatment.
3. Fluoride treatment—Once every 12 months up to age 18 and only with cleanings.
4. Restorations—Limited to decay.
5. Relines—Permitted once per year.
6. Crowns—Allowable only where extensive coronal destruction is evident by x-rays or can be demonstrated by study models, and the tooth is beyond restoration with amalgam or composite resin.
7. Replacement of crowns, bridges or dentures—Limited to once in five years of the original date of placement.
8. Fixed bridges—Covered only when a removable partial cannot satisfactorily restore the case.
9. Bridgework—On fully erupted permanent teeth only.
10. Subgingival scaling, periodontal curettage, recall or root planing—Only when need can be shown by x-rays or written report and are limited to four quadrants per calendar year.
11. Space maintainers—Only where there is adequate space to permit eruption of permanent teeth. Appliances to hold space for missing permanent teeth are not covered benefits.
12. Gold or porcelain restorations—Not provided on primary teeth.

Exclusions

1. Costs and services received from non-panel providers are not paid to you or the provider except as authorized in writing by *Bright Now!* Dental.
2. Professional providers have the right to refuse treatment to a patient who continually does not follow a prescribed course of treatment.
3. Specialty referral must be pre-authorized by *Bright Now!* Dental in writing.
4. When more than one procedure may be considered, the Plan allows the least expensive procedure.
5. Amalgam, composite or cement build-ups are not a separate benefit, but are considered part of the completed restoration.
6. Composites or porcelain posterior to the second bicuspid are considered cosmetic and are not covered.
7. Denture replacements (full or partial) are made only if existing denture is unsatisfactory and cannot be made satisfactory.
8. Porcelain crowns posterior to the second bicuspid are considered cosmetic dentistry and are not covered.
9. Dowel posts or pins are not covered except where insufficient coronal structure remains to retain the crown restoration.
10. If the attending dentist determines teeth to have questionable, guarded or poor prognosis, endodontic treatment, periodontal surgery and crown or bridgework are not covered for such teeth. *Bright Now!* Dental allows for observation or extraction and prosthetic replacement only.
11. Any services not listed as covered in *Bright Now!* Dental's printed materials are not covered.
12. Services which the attending dentist considers as not necessary for the patient's dental health are not covered.
13. Services for injuries or conditions covered by Workers' Compensation or employers' liability laws for accidental injuries are not covered.
14. Services provided without cost by any city, county or other government agency are not covered.
15. Services performed for cosmetic, elective or aesthetic purposes are not covered.
16. Hospitalization, general anesthesia, analgesia, intravenous sedation or prescription drugs are not covered by *Bright Now!* Dental.
17. Any procedures or services listed as a benefit that the *Bright Now!* Dental provider cannot perform due to the patient's general health, physical, behavioral or management problems, are not covered.
18. Specialty referrals are not covered unless specifically pre-authorized or included.
19. Replacement of teeth missing prior to this dental coverage becoming effective.
20. Restoration of tooth structure lost due to erosion or abrasion is not covered.
21. Replacement due to loss or theft of appliance is not covered.
22. Dentures, partial dentures and reline allowances include adjustments for a six-month period following installation. Fees for specialized techniques involving precision dentures, personalization or characterization must be paid by the patient.
23. Periodontal splinting is not covered.
24. Oral surgery requiring the setting of fractures, dislocations or for orthodontic treatment is not covered by *Bright Now!* Dental. Check your TBT medical option for coverage.
25. Any implantations, including fixed or removable prosthetics related to experimental procedures, are not covered.
26. Treatment for crown exposure and ligation and crown lengthening are not covered.
27. Preventive extractions for orthodontic purposes or other instances requiring repairs following major neoplastic surgery are not covered.
28. Services to treat congenital, hereditary or developmental malformations are not covered.
29. Orthodontics other than specifically stated are not covered.
30. Under any orthodontic benefits, treatment plans beginning before your TBT coverage was effective are not covered.
31. Temporomandibular joint syndrome (TMJ), occlusal equilibration and TMJ-related orthodontics and night guards are not covered.
32. Appliances or restorations needed to increase vertical dimension or restore the occlusion are not covered.

Orthodontic Limitations and Exclusions

1. Once covered orthodontic benefits begin, patients may not change orthodontists. If the treating orthodontist retires or leaves the panel, *Bright Now!* Dental reassigns a new orthodontist.
2. Cephalometric x-rays or tracings are not covered.
3. Lost or broken orthodontic appliances are not covered.
4. Treatment already in progress when coverage begins is not covered.
5. Changes in treatment caused by an accident are not covered. (See your TBT medical option for more information.)
6. Extraction of teeth for orthodontic purposes is not covered.
7. Surgical orthodontics, myofunctional therapy, cleft palate, micrognathia, macroglossia or hormonal imbalances are not covered.
8. Treatment that extends beyond 24 months is subject to an office visit charge.
9. Treatment for patients who continually do not follow a prescribed treatment plan are not covered.
10. Broken appointment charges beyond one per year are charged to the patient.
11. Participants or covered family members who are currently under orthodontic treatment with non-panel providers, are not eligible to enroll.
12. Orthodontic benefits are available to dependents up to age 26.

OPTION 3—UNITED HEALTHCARE DENTAL

Services Not Covered

The United Healthcare Dental option covers a wide variety of dental care services, but certain expenses are not covered. For your convenience, a list of limitations and exclusions is shown below. Not all details are included here. Check United Healthcare Dental brochures for limitations and exclusions.

Limitations

1. Prophylaxis—Limited to one treatment each six-month period (includes periodontal maintenance following active therapy).
2. Crowns, bridges and dentures (including immediate dentures)—No replacement within a five-year period from initial placement.
3. Partial dentures—No replacement within any five-year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Denture relines—Limited to one per denture during any 12 consecutive months.
5. Replacement is provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
6. Treatment for conditions is generally limited to conventional techniques and does not include splinting, hemisection implants, overdentures, grafting, precision attachments, duplicate dentures and bruxating appliances.
7. Crown or bridgework—Up to five units are covered. Upon the sixth unit, the treatment is considered to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit.
8. Periodontal treatments (root planing/subgingival curettage)—Limited to four quadrants during any 12 consecutive months.
9. Full mouth debridement (gross scale)—Limited to one treatment in any 24 consecutive month period.
10. Bitewing x-rays—Limited to not more than one series of four films in any six-month period.
11. Full mouth x-rays and/or panographic type films—Limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of six periapical films plus bitewing x-rays.
12. Sealant benefits—Include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age 9 and second molars and bicuspids up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
13. Single unit cast metal and/or ceramic restorations and crowns—Covered only when the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays.
14. Cosmetic dental care—Limited to composite restorations on posterior teeth "distal to canines" when the dentist determines treatment to be appropriate dental care. Composite restorations are covered on premolar facial surfaces.

Exclusions

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs.
2. Dental conditions arising out of and due to participant's employment or for which Worker's Compensation is payable. Services that are provided to the participant by state government or agency, or are provided without cost to the participant by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
3. Treatment required by reason of war.
4. Dental services performed in a hospital and related hospital fees.
5. Treatment of fractures and dislocations.
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress before coverage began (such as teeth prepared for crowns, root canals in progress, fixed and removable prosthetics).
8. Any service that is not specifically listed as a covered expense.
9. Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and supernumerary teeth.
10. Treatment/removal of malignancies, cysts over 1.25 centimeters, tumors or neoplasms.
11. Dispensing of drugs not normally supplied in a dental office.
12. Treatment as a result of accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth.
13. Cases which in the professional opinion of the attending dentist determine that a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any dental office other than a United Healthcare Dental general dental office, unless expressly authorized in writing by United Healthcare Dental or as cited under "Out of Area Emergency Treatment" in their print materials.
15. Prophylactic removal of asymptomatic, nonpathological impacted teeth, extractions for orthodontic purposes; surgical orthognathic procedures and crown exposure with ligation.
16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
17. Crown lengthening procedures.
18. Replacement of longstanding missing tooth/teeth in an otherwise stable dentition.
19. Dental services and treatments for restoring tooth structure loss from wear, bruxism, attrition and/or erosion, changing or restoring vertical dimension, and full mouth reconstruction to enhance occlusion, diagnosis and/or treatment of the temporomandibular joint (TMJ).
20. Dental services that cannot be performed in the United Healthcare Dental general dental office because of physical, medical or behavioral limitations of eligible dependents over age 6.

Orthodontic Limitations and Exclusions

1. Start-up fees subject to additional combined charges not to exceed $200.
2. Start-up fees higher than $200 for cephalometric x-rays, tracings and study models and photos are not covered.
3. Orthodontic care prior to age 10 or after age 26. Orthodontic cases extending beyond the 26th birthday are subject to loss of benefit residual obligation provision.
4. Transfer of orthodontic provider for any reason in the middle of treatment.
5. Any treatment rendered by any noncontracted orthodontic provider.
6. Lost or broken appliances are not covered.
7. Retreatment of orthodontic cases is not covered.
8. Treatment in progress when you become eligible for dental coverage is not covered.
9. Changes in treatment caused by an accident of any kind are not covered (see your TBT medical option).
10. Extraction of teeth or surgical procedures for orthodontic purposes is not covered.
11. Cases involving surgical orthodontics, myofunctional therapy, cleft palate, temporomandibular joint dysfunction (TMJ), micrognathia, macroglossia, hormonal imbalances or Phase I orthodontic care are not covered.
12. Treatment that extends beyond 24 months is subject to an office visit charge.
13. Treatment for patients who continually do not cooperate with the orthodontist is not covered.
14. Treatment for those patients who continually do not follow a prescribed treatment plan is not covered.

Provider List	Phone Numbers	Address	Reasons to Call
TBT Plan Administration Office www.tbtfund.org	(510) 796-4676 (800) 533-0119	39420 Liberty Street, #260 Fremont, CA 94538-2200	TBT eligibility questions, enrollment forms (including HMOs), changes in family status, Open Enrollment forms, Employer contributions, Indemnity and PPO claims, disability waivers application, life and accidental death & dismemberment claims and other questions.*
Delta Dental www.deltadentalca.org	(800) 765-6003 or (888) 335-8227	P.O. Box 997330 Sacramento, CA 95999-7330	Dental Option 1 benefit questions.* For Delta Dental provider finder service or appeals, call (800) 427-3237 or visit the Delta Dental website.
Bright Now! Dental Newport Option www.brightnow.org	(800) 497-6453 (714) 668-1300	8105 Irvine Center Drive Irvine, CA 92618	Dental Option 2 benefit questions, network provider questions and service issues.*
United Healthcare Dental www.uhc.com/myhc	(800) 445-9090	P.O. Box 30567 Salt Lake City, UT 84130-0567	Dental Option 3 benefit questions, network provider questions and service issues.*

* **Note:** *For general enrollment information and dental option elections, address changes and changes in Dependent status, contact the TBT Plan Administration Office. Any required forms (including dental option change forms) are mailed to you by TBT. You may also download forms from the TBT website at www.tbtfund.org.*

This ***Comparison of Dental Benefits*** *is only a summary of the coverage actually provided by each of the specified programs. All exclusions and limitations of benefit coverage have not been listed and may vary by TBT Plan. The contents of this comparison are not to be construed or accepted as a substitute for the provisions of the Rules and Regulations of the Teamsters Benefit Trust Delta Dental Plan or the contracts with Bright Now! Dental or United Healthcare Dental, which control in case of conflict. See each organization's* ***Evidence of Coverage and Disclosure*** *form for the most current details. To maintain the financial stability of the Plan, the Trustees reserve the right to change the benefits, deductibles or copayments or to terminate the Plan at any time.*