TEAMSTERS BENEFIT TRUST

COMPARISON OF DENTAL BENEFITS

PLAN IV

REVISED APRIL 2013

COMPARISON OF DENTAL BENEFITS—PLAN IV

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 at (510) 796-4676 or (800) 533-0119.

Coverage begins for you and your covered dependents only after you choose a dental option by returning your *Dental Option Form*. Please read the *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 enclosed *Guide to Your Benefits*. If you have questions about eligibility or benefits, call the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

BENEFITS	SELF-FUNDED OPTION OPTION 1 INDEMNITY DENTAL (Delta Dental)	PRE-PAID DENTAL OPTIONS OPTION 2 BRIGHT NOW! DENTAL	 OPTION 3 PACIFIC UNION DENTAL
CHOICE OF DENTIST	You may choose any dentist, but your out-of-pocket expenses may be less if you choose Delta dentists.	You must choose a *Bright Now!* Dental dentist.	You must choose a Pacific Union 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 Pacific Union Dental dentist.
DEDUCTIBLE	None	None	None
CALENDAR YEAR MAXIMUM	$1,500	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	Paid at 70% if Delta dentist; if non-Delta dentist, 70% of UCR charges.	100% for covered services.	100% for covered services.
ORTHODONTIA	Not covered	Copayment of $1,800 to age 19; $2,450 age 19 and over (full-banded two-year case).	Copayment of $1,800 to age 19; $2,450 age 19 and over (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 your local *Bright Now!* Dental at (714) 668-1300. If not resolved, refer to *Guide to Your Benefits* for appeals procedure.	Contact Pacific Union Dental at (800) 999-3367. 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 *Guide to Your Benefits* and *Summary of Coverage* for any special rules or exceptions not mentioned below.

Limitations

1. Benefits are not payable for more than two oral examinations per calendar year, including office visits for examinations and specialist consultations (or a combination).
2. Benefits are not payable for more than two prophylaxis, fluoride treatments or procedures that include cleanings in a calendar year.
3. Bitewing x-rays are 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 age 18 and over. Full-mouth x-rays are provided once in a five-year period.
4. Sealant benefits include the application of sealants only to permanent first molars through age eight 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 three years of its application.
5. Crowns, caps, inlays, onlays and cast restorations are covered benefits on the same tooth only once every five years.
6. For a standard cast chrome or acrylic partial denture or a standard complete denture, the Plan pays its copayment percentage of the dentist's fees allowance (the average amount charged by most participating dentists. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.)
7. Prosthodontic devices are 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.
8. 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 50% if Delta dentist or 50% of UCR charges if non-Delta dentist. Covered expenses are payable at 50% 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.
9. 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. For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.
10. Diagnostic casts are a benefit only when made in connection with subsequent orthodontic treatment covered by this Plan.

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. Orthodontic treatment.
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 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 general anesthesia given by a dentist for covered oral surgery procedures).
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 are limited to decay.
5. Relines are permitted once per year.
6. Crowns are 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 is limited to once in five years of the original date of placement.
8. Fixed bridges are covered only when a removable partial cannot satisfactorily restore the case.
9. Bridgework is allowed on fully erupted permanent teeth only.
10. Subgingival scaling, periodontal curettage, recall or root planning are allowable only when need can be shown by x-rays or written report and are limited to four quadrants per calendar year.
11. Space maintainers are allowable 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 are 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 implants or 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. Orthodontic, lost or broken 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 only available to dependents up to age 19 (or to age 23 if a full-time student).

OPTION 3—PACIFIC UNION DENTAL

Services Not Covered

The Pacific Union 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 Pacific Union Dental brochures for limitations and exclusions.

Limitations

1. Prophylaxis is limited to one treatment each six-month period (includes periodontal maintenance following active therapy).
2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement.
3. Partial dentures are not to be replaced 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 are 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. Up to five units of crown or bridgework per arch 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) are limited to four quadrants during any 12 consecutive months.
9. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
10. Bitewing x-rays are 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 are 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 nine 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 are 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 is limited to composite restorations on posterior teeth "distal to canines" when a PUD 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 enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee 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, andodontia) 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 PUD 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 PUD dental office, unless expressly authorized in writing by PUD or as cited under "Out of Area Emergency Treatment" in the Pacific Union Dental brochures.
15. Prophylactic removal of asymptomatic, nonpathological impacted teeth, extractions for orthodontic purposes; surgical orthognatic 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 long standing 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 PUD general dental office because of physical, medical or behavioral limitations of eligible dependents over the age of six years.

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 ten or after the age of 19. Orthodontic cases extending beyond the 19th 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, macroglossis, 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 are not covered.
14. Treatment for those patients who continually do not follow a prescribed treatment plan is not covered.

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 or the contracts with Bright Now! Dental or Pacific Union 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 must reserve the right to change the benefits, deductibles or copayments or to terminate the Plan at any time.*