# TEAMCARE DENTAL BREAKDOWN

**Applies to Plan: U1/U3/U5/U7/1U/G1**

<table>
<thead>
<tr>
<th><strong>DENTAL</strong></th>
<th><strong>FREQUENCIES</strong></th>
<th><strong>ALLOWANCES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Limit</td>
<td></td>
<td>No Annual Limit</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td>No Deductible</td>
</tr>
<tr>
<td>Oral Exams</td>
<td>Every 6 months</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylaxis/Periodontal Cleanings</td>
<td>Every 6 months</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants (covered for children to age 14)</td>
<td>Every 18 months</td>
<td>100%</td>
</tr>
<tr>
<td>Full-mouth or Panorex X-rays</td>
<td>Every 2 years</td>
<td>100%</td>
</tr>
<tr>
<td>Bite-wings</td>
<td>Every 6 months</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride Treatment Children (to age 26)</td>
<td>Every 6 months</td>
<td>100%</td>
</tr>
<tr>
<td>Periodontal Procedures (submit charting and x-rays)</td>
<td>Every 12 months</td>
<td>100%</td>
</tr>
<tr>
<td>Restorative Procedures (Endodontics, Fillings)</td>
<td>Once per lifetime for root canal therapy</td>
<td>100%</td>
</tr>
<tr>
<td>Full or partial dentures and related procedures</td>
<td>Every 3 years for dentures</td>
<td>100%</td>
</tr>
<tr>
<td>Fixed bridgework, crowns, inlays, onlays and related procedures</td>
<td>Every 3 years for crown/bridgework</td>
<td>80%</td>
</tr>
<tr>
<td>Adjunctive General Services (Occlusal Guards, Consultations, etc.)</td>
<td>General Anesthesia payable in conjunction with eligible surgical procedures or under age 3</td>
<td>100%</td>
</tr>
<tr>
<td>Extractions, Oral Surgery and Anesthesia (submit x-rays with surgical extractions)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Implants and Related Procedures Not Covered. Pre-determination required for alternate treatment consideration.</td>
<td>Based on limitation for alternate treatment (3 years)</td>
<td>100% of Reasonable and customary for alternate treatment</td>
</tr>
<tr>
<td>Accidental Injury Dental</td>
<td>Payable under dental – supplemented under Medical-repair to natural teeth</td>
<td>Applicable Dental coverage/80% Major Medical</td>
</tr>
<tr>
<td>Orthodontia (children up to age 26 only)</td>
<td>PDB Requires: Total case fee, Length of treatment, Initial banding/appliance fee, monthly adjustment cost and diagnostic records if applicable</td>
<td>50% - No Annual Limit</td>
</tr>
<tr>
<td>TMJ-Non Cutting (dental related appliances paid under dental)</td>
<td>Payable Under Medical</td>
<td>80% Major Medical, $1,000 annual limit</td>
</tr>
</tbody>
</table>

There is no downgrading, missing tooth clause or waiting period. This is a calendar year plan with no effective dates given as we operate month to month. Payment is based on seat date and completion of service.
DENTAL BENEFITS SUMMARY

How Much Will TeamCare Pay Under This Benefit?
For covered dental treatments, the Plan will pay in accordance with the patient’s Plan Benefit Profile, subject to Humana Fee Schedules for providers in the Humana Network and Reasonable and Customary limitations for Out of Network Providers.

What Does This Benefit Cover?
Diagnostic and Preventive Dental Care

- Oral exams
- Bite-wing x-rays
- Fluoride treatments for children to age 26
- Full mouth or Panorex x-rays
- Prophylaxis (cleaning)
- Sealants for children thru age 13

Restorative Dental Treatments

- Fillings
- Root canal treatments and similar services

Extractions, Oral Surgery and Anesthesia

- Routine and Surgical Extractions
- General anesthesia when used in conjunction with oral surgery or 3 simple extractions
- Alveoplasties
- Removal of impacted teeth

Periodontal Surgery

- Periodontal scaling and/or root planing
- Mucogingival surgery and Gingival curettage
- Osseous graft and Osseous surgery
- Gingivectomies or gingivoplasty
- General anesthesia when used with qualifying procedures

Fixed and Removable Prosthetic Devices and Related Services

- Full or partial dentures (including overdentures)
- Repair of dentures, partials, bridges and crowns, relines, rebases
- Fixed bridgework, crowns, inlays and onlays

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Procedures Subject To Time Limitations

- For inlays, onlays, crowns, bridgework, dentures or prosthetic devices: Expenses for replacement made less than 3 years after placement or replacement are not covered by the Plan. The Plan will, however, cover newly extended area.
- Expenses for adjustments, tissue conditioning, relining and/or rebasing, which are less than 6 months after insertion of dentures are not covered by the Plan.
- Expenses for labial veneers/laminate unless due to accident, fracture or birth defect, which are within 3 years of previous payment for labial veneers are not covered by the Plan.
- Expenses for dental laboratory relining made less than 3 years after the previous payment for relining are not covered by the Plan.
- Expenses for rebasing of dentures made less than 3 years after previous payment for rebasing are not covered by the Plan.
- Expenses for either full mouth or panoramic x-rays more than once in any two-year period are not covered by the Plan.
- Expenses for bite-wing x-rays, fluoride application, oral examination or prophylaxis or periodontal prophylaxis (cleaning) more than once in any six-month period are not covered by the Plan.
- Expenses for root canal therapy, apicoectomy, and hemisection more than once in a lifetime per tooth (root), are not covered by the Plan.
- Expenses for scaling and/or root planing more than once in any one (1) year period are not covered by the Plan.

Does This Benefit Cover Any Treatment After the Patient’s Plan Coverage Ends?

Yes. Certain dental treatments that take a long time to finish will be payable after the patient’s Plan coverage ends if they are started while the patient is covered. Following are those procedures which are covered based on the date that work was begun:

- The completion of dentures (full or partial) is payable if the patient was covered on the date the impression was made.
- The completion of fixed bridgework, gold restorations and crowns is payable if the patient was covered on the date the tooth or teeth were prepared.
- The completion of root canal therapy (endodontics) is payable if the patient was covered on the date that the tooth or teeth were opened for treatment.

Note: In order to be covered for the above procedures, they must be fully completed within one year of the date that treatment was started.
What are the Exclusions and Limitations under this Dental Plan?

- Any amount over the Reasonable and Customary allowance established by the Fund;
- Treatment by someone other than a Dentist or doctor, except for cleaning and scaling of teeth and application of fluoride treatment and/or sealants by a licensed dental hygienist when such services are rendered under the direct supervision and guidance of the Dentist;
- Services and/or supplies for cosmetic purposes;
- Services and/or supplies that are experimental in nature;
- Orthodontic services and/or supplies for a Covered Participant or Spouse, including orthodontia in conjunction with TMJ and/or other medical/dental conditions;
- Services and/or supplies which are not considered standard dental / medical care or medically necessary, or which are not necessary according to those standards professionally endorsed by the general dental community;
- Services and supplies for which the Covered Individual is not legally required to pay;
- Precision attachments, specialized techniques and personalization or characterization of dental prostheses;
- Procedures, restorations and appliances to increase vertical dimension (the distance between the nose and chin);
- Educational programs, such as plaque control, oral hygiene instruction or nutritional counseling;
- Sealants for Participants, Spouses or a Child past their fourteenth (14th) birthday;
- Sealants more than once in any eighteen (18) month period for children under their fourteenth (14th) birthday;
- Implantology (except for subperiosteal, mandibular staple bone, osseointegrated biotes or mucosal implants to anchor full dentures only);
- Replacement of lost, missing or stolen dental/orthodontic appliances;
- Failure to keep a scheduled visit with a Dentist or hygienist;
- Completion of any dental claim forms;
- Local anesthesia, analgesia or nitrous oxide;
- Prescriptions written by the Dentist;
- Dental treatment for a Dependent Child past their (26th) birthday;
- Temporary restorations or sedative fillings on the same day as restorative dentistry;
- Bases which are in connection with restorative dentistry;
- Crowns without sufficient breakdown or sufficient decay;
- Crowns and/or bridgework without sufficient bone support;
- Crowns and/or bridgework supported by implants;
- Expenses for multiple periodontal procedures performed on the same day;
- Expenses for periodontal procedures performed on Dependent Children (will be individually reviewed for possible payment);
- Expenses for space maintainer for Participant or Spouse;
- Expenses for home medicaments;
- Any procedure not completed;
• Permanent crowns and/or bridgework on deciduous (baby) teeth;
• Root canal therapy, apicoectomy, root resection and hemisection more than once in a lifetime per tooth (root); and
• General anesthesia; unless administered in conjunction with oral surgery (impacted or surgical extractions), periodontal surgery, fracture, dislocations, apicoectomies, or three (3) or more simple extractions rendered on the same date of service

Special Techniques Which Are Not Covered

• Precision attachments, specialized techniques, and personalization of dental prosthesis
• Procedures, restorations and/or appliances to increase vertical dimension (the distance between the nose and chin)
• Implantology (except for endosseous staple implants and subperiosteaal to support full dentures)
• No more than two consecutive abutments on any fixed bridge-work (crowns splinted and extended beyond this will be payable as individual crowns)
• Expenses for extension of bridges or prosthetic devices previously paid for by this Plan, except for expenses for new extended areas

This document is intended as a summary only. All benefits will be paid in accordance with the Benefit Plan Document. All Amounts Payable shown are for Covered Services and are subject to Reasonable and Customary (R&C) limitations.

Important: Eligibility information provided is based on current information supplied to the Fund. The eligibility and benefit information provided is not a guarantee of benefits. The actual benefits paid are based upon receipt of contributions to cover the dates of service and in all cases; the Plan Document will determine the amount of benefits payable. The Plan does not provide benefits for services considered as cosmetic care, care that is not considered standard medical care, maintenance care, or for services considered not medically necessary.

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