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 Reasonable and Customary limitations.

What Does This Benefit Cover?
Diagnostic and Preventive Dental Care

- Oral exams once every 6 months
- Bite-wing x-rays once every 6 months
- Fluoride treatments for children once every 6 months
- Full mouth or Panorex x-rays once every 2 years
- Prophylaxis (cleaning) once every 6 months
- Sealants for children thru age 13 once every 18 months

Restorative Dental Treatments and Extractions

- Fillings and routine extractions
- Root canal treatments and similar services

Oral Surgery and Anesthesia

- General anesthesia when used in conjunction with oral surgical procedures
- Alveoplasties
- Removal of impacted teeth

Periodontal Surgery

- Periodontal scaling and/or root planing once every 12 months
- Mucogingival surgery and Gingival curettage
- Osseous graft and Osseous surgery
- Gingivectomies or gingivoplasty
- General anesthesia when used with qualifying periodontal procedures
- Periodontal prophylaxis once every 6 months
Fixed and Removable Prosthetic Devices and Related Services

- Full or partial dentures (including overdentures) once every 3 years
- Repair of dentures, partials, bridges and crowns
- Fixed bridgework, crowns, inlays and onlays once every 3 years

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 areas.
- 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.

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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 nineteenth (19th) 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 subperiosteal 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.