New York State Teamsters Council Health & Hospital Fund

Dental Plan

Basic and Major Dental Benefits

Effective January 1, 2026

Your Funds……Working For You

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BASIC AND MAJOR DENTAL BENEFITS

Basic and Major Dental Benefits ("Plan") are self-funded by the New York State Teamsters Council Health & Hospital Fund ("Fund") and administered by Excellus BlueCross BlueShield.

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SECTION 1

ELIGIBILITY RULES FOR NEW PARTICIPANTS AND NEW EMPLOYERS

Eligibility for Basic Dental Benefits provided by the Fund is determined by the Fund in accordance with the Fund's Eligibility Rules which are contained in the General Eligibility & ERISA Rights Information booklet provided by the Fund. You must complete one year of **continuous** eligibility before you or your dependents become eligible for Major Dental Benefits.

OPT OUT

Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

DENTAL BENEFIT OPTIONS

The Dental Benefit Options available under the Plan.

Option 1: Full Basic and Major Dental Benefits with $5,000 Annual Limit per Individual
Option 2: Full Basic and Major Dental Benefits with $750 Annual Limit per Individual
Option 3: Full Basic Dental Benefits only

The Dental Benefit Option that applies to you and your dependents is determined by the contribution rate paid to the Fund and the Benefit Selection Form signed by your employer and

your local union. If you have any questions concerning the Dental Benefit Option that applies to you and your dependents, you may contact the Fund Office.

SECTION 2

BASIC DENTAL BENEFITS

Basic Dental coverage includes the following services:

1. **Diagnostic**
   - **a.** Oral exams – Initial, Periodic & Emergency Treatment (2 per person per calendar year)
   - **b.** Radiographs – Complete series, Panorex, Periapicals and Bitewings. The Plan allows one full mouth complete series or one Panorex X-ray per person in any thirty-six (36) month period. The Plan allows for bitewings twice per calendar year.

2. **Preventive**
   - **a.** Dental Prophylaxis (2 per person per calendar year)
   - **b.** Fluoride Treatments (Limited to persons less than age 19 and limited to one treatment per person per calendar year)
   - **c.** Sealants (Limited to person less than age 19, applies to molars and premolars only, and to one treatment per tooth in a three (3) year period)
   - **d.** Space Maintainers (Limited to persons less than age 19 and a total of two (2) per person)

3. **Basic Restorative (Fillings)**
   - **a.** Amalgams (Primary and Permanent teeth)
   - **b.** Composite (Primary and Permanent teeth)

4. **Endodontics (Root Canal Therapy)**

5. **Periodontics (Gum Treatment)**
   - **a.** Flap entry and closure is part of the allowance for Osseous surgery and Osseous graft and not a separate dental service.
   - **b.** Periodontal Maintenance Treatment (2 per person per calendar year following active treatment)

6. **Maintenance of Prosthodontics**
   - **a.** Complete and partial dentures. Any adjustments of or repair to a denture or partial denture within six (6) months of its installation is not a separate covered dental service.
   - **b.** Re-cementing a crown or bridge
   - **c.** Crown repair

7. **Oral Surgery**

a. Simple Extractions
b. Surgical Extractions
c. Soft tissue Impaction
d. Partial Bony Impaction
e. Complete Bony Impaction
f. General Anesthesia or Intravenous Sedation only allowed in connection with surgical extractions (Nitrous Oxide sedation is not a covered treatment)

Local anesthetic, analgesic and routine post-operative care for extraction and other oral surgery are part of the allowance for each dental service.

Payment for covered services under this Plan is based upon allowable amounts as approved by the Fund. A complete Schedule of Allowances is available from the Fund Office or Excellus BlueCross BlueShield. You are responsible for any amounts not paid by the Fund.

SECTION 3

MAJOR DENTAL BENEFITS

Major Dental coverage includes the following services:

1. Crowns (Porcelain; porcelain fused to metal, full cast; ¾ cast)
2. Complete Dentures
3. Partial Dentures
4. Fixed Bridges (Abutments and Pontics)
5. Orthodontics (Charges in excess of Plan Allowance are the responsibility of the patient)

All services covered under Major Dental Coverage require a Pre-determination of Benefits to be completed prior to the start of any service.

Payment for covered services under this Plan is based upon allowable amounts as approved by the Fund. A complete Schedule of Allowances is available from the Fund Office or Excellus BlueCross BlueShield. You are responsible for any amounts not paid by the Fund.

SECTION 4

DENTAL BENEFIT PROVISIONS

PRE-DETERMINATION OF BENEFITS

A Pre-determination of Benefits **must** be completed and filed with Excellus BlueCross BlueShield for a proposed course of treatment for any of the following:

1. Complete Dentures;
2. Partial Dentures;
3. Crowns;
4. Bridgework; or
5. Orthodontic Treatment

It is also recommended that a Pre-determination of Benefits be submitted for the following procedures:

1. A treatment course which will exceed **$300** in cost;
2. Root canal therapy;
3. Crowns;
4. Periodontal treatment; or
5. Extensive oral surgery.

The dentist must send a written report showing the planned treatment to Excellus BlueCross BlueShield. An estimate of the dentist's charges must also be submitted. You and your dentist will be notified of any benefits payable within 15 days of receipt of all necessary information.

The pre-determination of benefits evaluation does not guarantee final payment; it is an estimate only. Final payment will be based upon such factors as the actual work completed, patient enrollment eligibility, any primary plan coverage, plan schedule and benefit maximums in effect on the date the services are rendered. A pre-determination of benefits will remain valid for six (6) months from the date of issue.

Alternate Procedure

If Excellus BlueCross BlueShield determines that the alternate procedures or an alternate course of treatment can be performed to correct a dental condition, benefits covered under the Plan will be considered for the least costly procedure which Excellus BlueCross BlueShield determines:

- is customarily used nationwide for the treatment of the dental condition; and
- are deemed by the dental profession to be appropriate for treatment of the dental condition; and
- meets broadly accepted national standards of dental practice.

If you elect to proceed with the originally proposed course of treatment, benefits are limited to the eligible benefits as determined by Excellus BlueCross BlueShield in accordance with the above rules. Additional charges will be your responsibility.

If a treatment plan is not provided to Excellus BlueCross BlueShield in advance, benefits will be paid on the basis of the alternate procedures, which would have been proposed had a treatment plan been submitted. This amount may be less than the amount which otherwise would be payable.

SECTION 5

DENTAL CARE LIMITATIONS

Orthodontic Lifetime Maximum

Members and Dependents is $ 4,300.00 per individual.

Clinical Oral Examinations

Maximum of two (2) per calendar year.

Radiographs

Bitewings twice per calendar year.
One full mouth complete series or one Panorex every thirty-six (36) months.

Prophylaxis

a. Routine – Maximum of two (2) per calendar year.

b. Periodontal Maintenance – Maximum of two (2) per calendar year following active treatment.

Fluoride Treatments

Only to age 19 and limited to one (1) per calendar year.

Space Maintainers

Only to age 19 and limited to two (2) per person.

Temporary Fillings

Not Covered.

Pulp Capping/Cement Bases

These are considered integral parts of the restoration and are not covered per se.

Crown and Gold Fillings

Limited to one (1) crown per tooth for a period of five (5) years. The Fund will pay for crowns and gold filling only if the tooth cannot be restored.

Extractions

Routine removal of tooth or a retained root. This fee will include local anesthesia and any necessary x-rays.

Consultation

Covered **only** for the following specialties: Oral Surgery, Orthodontics, Periodontics and Endodontics. A consultation is not covered on the same day as actual services, except for x-ray examinations.

Periodontal Surgery

Repeated periodontal surgery will not be covered for a period of three (3) years.
Periodontal scaling/root planing is allowed once per quad per 12 months.
One full mouth debridement is allowed every 12 months.

Oral Surgery

Fractures are to be verified on request by pre and post-operative x-rays and operative reports. Oral surgery allowances include x-ray films taken solely in connection with the surgery, related local anesthesia and pre- and post-operative care. Oral surgery is to be verified on request by pre- and post-operative x-rays and operative reports.

Anesthesia

Anesthesia (including general anesthesia or intravenous sedation) is only covered in conjunction with oral surgery. No coverage is provided for nitrous oxide sedation.

Prosthetics

Predetermination Required

Duplication (Jump) rebase or chairside reline to a denture, partial or full denture, is limited to one (1) per denture per three (3) year period.

The Fund will not pay for fixed or removable splints for periodontal or other reasons, except when a missing tooth is replaced. Only the portion of the splint replacing the missing tooth will be covered. Splints using enamelite or other similar material replacing missing teeth will not be covered.

The Fund will not pay for the rebase or repair of a newly inserted denture (partial or full) for a period of six (6) months following insertion, nor for the addition of a tooth to replace a natural tooth extracted subsequent to insertion, nor for the addition of a clasp.

The Fund will not pay for replacement of a crown, fixed bridge or denture, which is less than five (5) years old.

Implants are **not covered** and crowns and/or pontics over implants are **not covered**.

The Fund will not pay for crowns or pontics for attachment to or clasp purposes unless that tooth is so broken down it cannot be restored properly by fillings. This also applies to a cantilever pontic when used for attachment reasons for a partial in the same jaw.

The Fund will not pay for dental treatment for cosmetic or aesthetic reasons.

Acrylic crowns must be laboratory processed and permanent, and will only be paid as single crowns (never as bridge abutments or splints). Acrylic crowns will only be covered on the six (6) anterior teeth (cuspid to cuspid).

The Fund Does Not Cover:

1. The replacement or substitution for any type of prosthetic service and appliance, if the Fund made any payment toward the cost of the original installation of such service or appliance, unless five (5) years have elapsed since the Fund's previous payment. This exclusion applies even if additional teeth are involved in the replacement or substitution. All allowances for appliances include adjustment for a period of one (1) year.

2. Secondary or multiple abutments. A second crown or inlay used as a support for the primary crown in connection with fixed bridgework is not covered unless the second supportive crown or inlay was required for the restoration of the tooth.

3. Services or appliances used solely as an adjunct to periodontal care, any dental technique, whether for services or appliances, used in the stabilization of teeth unless there are missing teeth involved in the treatment.

ORTHODONTIC:

Predetermination Required

If the Fund has previously paid for a preliminary appliance, the amount will be deducted from the appliance benefit.

Habit breaking devices or adjustments thereof are **not covered**.

Each period of active monthly orthodontic treatment is considered a separate dental service. Benefits will not be paid for treatment received for orthodontic services after the termination of coverage or for the monthly treatments when an appliance is inserted before a person is eligible for benefits. However, the full course of treatment, including ongoing monthly treatments, required for orthodontic care with Invisalign® or similar providers shall be considered active monthly orthodontic treatment and covered up to the Lifetime Limit.

SECTION 6

WHEN TREATMENT BEGINS

All dental services will be considered to begin on the date the actual service is performed, regardless of the date the dentist recommended the service.

1. Dentures or Fixed Bridgework

The incurred date for dentures or bridgework is the date the impression is taken, not the date inserted. In situations where more than one impression is taken, the date of the final impression is considered as the date the expense for the denture or fixed bridge is incurred.

2. Crown

The expense for crowns will be deemed incurred on the date the tooth was prepared (filed) for crowning, not the date it was cemented in place.

3. Root Canal Therapy

Root canal therapy will be considered incurred on the date the work on each individual tooth began, regardless of the number of canals and the sequence of visits in their treatment. Visits after the effective date of coverage for treatment that commenced prior to the effective date will not be covered. Treatment to a tooth that commenced prior to the termination date of coverage will be covered.

4. Orthodontia

Benefits for orthodontic treatment will be provided only for treatment received for an appliance placed after the effective date of these Dental Care Benefits for the individual. The charge for extractions required before appliances are inserted and active treatment begins, will not be regarded as pre-orthodontic care chargeable to the orthodontic maximum. If pre-orthodontic expenses (diagnosis, evaluation, and pre-orthodontic care) are incurred while eligible for benefits, but the first appliance is not inserted until after eligibility terminates, the course of orthodontic treatment will not be considered as having commenced.

SECTION 7

PAYMENT OF BENEFITS

You have the right to select any licensed dentist for treatment or services. The amount paid by the Fund for covered services is based upon the Schedule of Dental Plan Allowances and is determined by the Board of Trustees. Every service or procedure performed by a dentist is assigned an amount based on the American Dental Association (ADA) procedure code. The Fund will pay the lesser of the amount contained in the Schedule of Dental Plan Allowances or the amount charged by the dentist. The payment made by the Fund will be the same whether a Participating Dental Provider or Non-Participating Dental Provider renders the service.

Participating Dental Providers

A Participating Dental Provider is a dentist who has a signed agreement with the Fund. Participating Dental Providers will accept the Fund's payment as payment in full for covered services. Payments for all covered services will automatically be paid to a Participating Dental Provider. When payment is made to a Participating Dental Provider, you will receive an Explanation of Benefits detailing the payment to the provider. If a service is not covered under the Plan, you are responsible for payment to the Participating Provider for the service.

Excellus BlueCross BlueShield will provide information concerning Participating Dental Providers. Also, this information will be available on the Fund's website at *www.nytfund.org*, with a link for claim forms and dental providers. As a dental provider's status may change, you should contact Excellus BlueCross BlueShield or the Fund Office to be certain the dental provider is a Participating Dental Provider with the Fund.

Non-Participating Dental Providers

A Non-Participating Dental Provider is a dentist who does not have a signed agreement with the Fund. If services are received from a Non-Participating Dental Provider, you will usually have a balance over and above the amount paid by the Fund for which you will be responsible. When services are received from a Non-Participating Provider, payment will be made directly to you, unless there is an assignment of benefits.

SECTION 8

SUBMISSION OF CLAIMS

When you receive services from a Participating Dental Provider, that provider will submit the claim directly to Excellus BlueCross BlueShield. Payment will be made directly to the Participating Dental Provider.

If you are treated by a Non-Participating Dental Provider, you will be billed, or may be required to pay the provider at the time services are rendered. You must complete a claim form and submit this along with an itemized bill to Excellus BlueCross BlueShield. Follow the directions on the claim form.

If you do not receive an itemized bill, then the Non-Participating Dental Provider must fully complete the dentist's portion of the claim form, and you must then submit the completed form for payment.

All claims for services must be received by Excellus BlueCross BlueShield within three hundred sixty five (365) days from the date the service is rendered. Claims received after the three hundred sixty five (365) days cannot be considered for payment. However, there is the following exception:

If you have been unable to file a claim with Excellus BlueCross BlueShield within three hundred sixty five (365) days of receiving a covered service because you have filed the claim in a timely manner with another insurance company or Plan, which may be responsible for payment of the claim, then you have up to ninety (90) days, from the date of final determination of the claim by the other insurance company or plan, to file the claim with this plan.

The Plan's procedures concerning initial determinations, adverse benefit determinations and appeals are set forth in Section 7 of the General Eligibility & ERISA Rights Information booklet provided by the Fund.

SECTION 9

NON-COVERED SERVICES

While the Fund provides benefits for most dental services, you and your dependents are not covered for the following:

1. Cosmetic surgery or cosmetic or aesthetic treatment.

2. Services for which no charge is incurred.

3. Services that are not normally performed according to accepted standards of dental practice.

4. Services that will be covered or partially paid for by No-Fault automobile insurance.

5. Treatment of dental disease, injury or defect arising in the course of any occupation, including volunteer organizations where Workers' Compensation Benefits are provided.

6. Treatment necessitated by war, declared or undeclared.

7. Treatment provided by a dental or medical department maintained by any employer, mutual benefit association, union, trustee or similar type group.

8. Services, supplies or treatment provided by Federal or Local government agency, unless required by law.

9. Replacing stolen, broken or lost prosthetic or orthodontic appliances.

10. Charges for broken appointments or for preparation of claim forms.

11. Implants or crowns or pontics over implants.

12. Educational or training programs or dietary instructions.

13. Experimental procedures.

14. Extra sets of dentures.

15. Supplies necessary for proper dental care.

16. Non-submitted claims or claims more than three hundred sixty five (365) days after dental work has begun.

17. Replacement of congenitally missing teeth, even if the primary tooth that should have been replaced by that missing tooth is extracted or lost due to other circumstances.

18. Diagnosis or treatment of any form of Temporomandibular Joint Disease or Syndrome.

19. Bleaching or whitening of vital or non-vital teeth.

20. Services for which benefits are provided under any other benefit program or contract with the Fund.

21. Habit breaking devices or adjustments thereof.

22. Procedures not detailed in the Schedule of Dental Plan Allowances.

23. Temporary appliances.

24. Nitrous oxide sedation.

25. The Plan does not cover any service not specifically listed as a covered service by the Plan.