



Health and Welfare Fund

Teamsters Local Union No. 856

1000 Marina Blvd Ste 400 • Brisbane CA 94005-1841 • Phone (800) 297-4595

August 2016

TO: Active Participants Enrolled in the Direct Pay Indemnity Dental Plan

FROM: Board of Trustees

RE: Dental Preferred Provider Network – First Dental Health



Several years ago the Plan contracted with First Dental Health, a dental Preferred Provider Network. This is a network of dentists who have agreed to fees that will result in savings to both the Plan and participants who use participating dentists.

This network is available for participants who are enrolled in the Teamsters Local 856 Direct Pay Dental Plan (the Indemnity Plan). This network does not apply to those participants enrolled in UHC Dental (formerly PUD) or PMI.

Contracting with First Dental Health offers the following:

- Discounts on all procedures performed by First Dental Health providers all the time, while eligible (including non-covered services). Discounts apply even after you've exceeded your plan's annual maximum.
- Although you are allowed to use any dentist of your choice, First Dental Health offers over 17,000 PPO provider locations statewide.
- All First Dental Health Network dentists are licensed, insured, and in good standing with the dental community.



TEAMSTERS LOCAL UNION No. 856
HEALTH and WELFARE FUND



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DENTAL PLAN INFORMATION CARD

Group No. TM856

Plan Administrator: Northwest Administrators, Inc.

www.firstdentalhealth.com

This card is not proof of identity or eligibility

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(Please see reverse side)

Attached please find your First Dental Health ID card. Your ID card is being sent to you for the following reason:

- Updated information with the new Plan Administrator – Northwest Administrators, Inc.

Present this card when you visit your dentist. It will identify that you are using the First Dental Health Network and provides the dentist with information on where to submit claims. Even if you are not changing dentists, present this card to your dental office because your current dentist may already be a First Dental Health PPO provider.

To find a participating First Dental Health PPO dentist, please go to www.firstdentalhealth.com or call First Dental Health at (800) 334-7244. Customer Service is available Monday – Friday from 8 a.m. to 5 p.m. PST.

If you have any questions regarding claims, eligibility or benefits, please contact the Trust Fund Office at (800) 297-4595.

DF:sa

For information on eligibility, benefits and claims, please contact Northwest Administrators, Inc. at (800) 297-4595

**Submit all claims to:
First Dental Health
P.O. Box 919029
San Diego CA 92191**

For information on participating dentists (i.e., to locate a dentist), please contact FDH at (800) 334-7244.

This card is not proof of identity or eligibility.

856-FDH-IDC



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856-FDH-IDC



SCHEDULE OF DENTAL PROCEDURES AND ALLOWANCES **(Applies to Plans I and C Direct Pay Dental Plans Only)**

Optional Services

In all cases in which you select a more expensive plan of treatment than is customarily provided, the Plan will pay on the basis of the lesser fee. You must pay the entire remainder of the dentist's fee. Some examples are:

1. **Partial Dentures.** If a cast chrome or acrylic partial denture will restore the denture, the Plan will allow the cost of such procedure toward a more complicated precision appliance that you and your dentist may choose to use.
2. **Complete Dentures.** If in the construction of a denture you and your dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow the appropriate amount for the standard denture toward such treatment and you must bear the difference in cost.

Dental Plans II, III and IV only

If an active employee or his dependent requires dental treatment, the Plan will pay the usual, customary and reasonable charges for the necessary dental services or supplies in accordance with the following.

Plans II and III have a yearly maximum of \$2,000 per participant. Plan IV has a yearly maximum of \$3,000 per participant.

Plan III has an annual deductible of \$50 per individual or \$150 maximum per family, applicable to all treatments and services EXCEPT diagnostic and preventive treatment. Plans II and IV do not have annual deductibles.

Diagnostic and Preventive treatment claims are paid at 100% of Usual, Customary and Reasonable Charges for Plans II, III and IV.

Oral Surgery, Periodontics and Restorative Procedures are paid at 90% of Usual, Customary and Reasonable Charges for Plans II and IV and at 80% of Usual, Customary and Reasonable Charges for Plans III.

Prosthetic Services are paid at 90% of Usual, Customary and Reasonable Charges for Plans II and IV and at 80% of Usual, Customary and Reasonable Charges for Plan III.

Dental Plans I and C only

If you or any of your eligible dependents receive dental treatment as described in the Schedule of Dental Procedures and Allowances you will be paid the lowest of the following amounts:

1. The amount of expense charged for the procedure.
2. The applicable amount specified in the Schedule of Dental Procedures and Allowances, or
3. Where more than one procedure may be considered as alternate treatment, the amount shown for the less expensive procedure.

An expense is deemed to be incurred on the date the service or supply which gives rise to the expense is rendered.

DIRECT PAY DENTAL BENEFITS

HOW TO USE YOUR PLAN

Make an appointment with your dentist explaining at that time that you are a member of the Teamsters Local Union No. 856 Dental Benefit Plan. Your dentist will perform any necessary examinations and plan the treatments required. It is advisable to show your dentist the Schedule of Dental Procedures and Allowances (if you are covered under Dental Plan I or C) included in this brochure. Discuss with him the fee he will charge as you may be required to pay part of the bill.

PREDETERMINATION OF BENEFITS

Predetermination of Benefits allows you to know what services are covered and what payments will be made for treatment performed before the work is done. If you or one of your family plans to incur dental expenses over \$350, you should ask your dentist to file for Predetermination of Benefits. This assures that both you and the dentist will know in advance just what part of the dentist's charges the plan will pay. Here's how it works:

1. The dentist informs the Fund Office of the proposed course of treatment by itemizing the service and charges on the claim form which you provide.
2. The Fund Office then determines the amount the plan will pay and informs you and the dentist of its estimated benefits. You and your dentist should discuss the result before treatment is started.

Predetermination of Benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures.

If you do not request Predetermination of Benefits, the Plan will pay the claim based on whatever information it has available. Predetermination of benefits could save you money (see section on Alternate Procedures).

ALTERNATE PROCEDURES

Often there is more than one way to treat a particular dental condition. For example, missing teeth may be replaced with fixed bridgework or with removable partial dentures. Decayed teeth may be restored with inlays and crowns or with direct placement fillings. When there are alternate treatments available the plan will pay benefits based on the least expensive procedure that falls within the standards of care. Whenever the Alternate Procedures provision is applied, the claim will be reviewed by the Plan's dental consultant.

The Predetermination of Benefits provision of the Plan is important and encouraged because, under the Alternate Procedures provision, the Plan has the right to pay benefits based on the most economical method of treatment that falls within the standards of care.

If benefits for an Alternate Procedure are paid, these benefits may be applied toward whatever treatment plan is selected by you and your dentist. If you and your dentist decide upon a more costly treatment, then you would be responsible for the additional charges beyond those paid by the Plan.

HOW TO FILE YOUR CLAIM

Obtain a Dental Plan claim form from the Fund Office or Local Union 856. After completing your portion, present it to the dentist on your first appointment.

Submit your claim without delay. Your claim must be presented within 120 days of the date you and your dependent receive the dental treatment.

Eligibility and claims payments are determined by the Fund Office.

DIRECT PAY DENTAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

Diagnostic

Routine oral examination including necessary x-rays but not more than one full mouth series of x-rays in a period of three (3) consecutive years, and not more than two (2) oral examinations in a calendar year.

Preventive

Oral prophylaxis (cleaning of teeth), but not more than two (2) such oral prophylaxis in a calendar year.

Sealants

First permanent molars on patients through age 14 years. Occlusal surface must be intact and caries free.

Oral Surgery

The surgical extraction of diseased or accidentally injured, erupted or unerupted teeth including pre-operative and post-operative care rendered in the dental office.

Periodontics

The treatment, surgical or nonsurgical, of tissues of the oral cavity or supporting tissues of the teeth, provided such service is rendered in the dental office.

Endodontics

Pulpal therapy and root canal procedures for the treatment of diseased teeth.

Restorative

Restoration of teeth with amalgam, synthetic porcelain and plastic restorations. Restorations of permanent teeth with gold, gold crowns, porcelain jackets and plastic jackets, or porcelain, plastic or acrylic fused to metal, but only when the permanent tooth cannot be restored with amalgam, synthetic porcelain, or plastic restorative material. Replacement of gold crowns and plastic jackets, or porcelain, plastic, or acrylic fused to metal provided the original crown or jacket was installed **more than five (5) years prior** to the replacement.

Prosthetic Services

The initial installation of full or partial dentures or fixed bridgework, provided that the installation is required as a result of the extraction of one or more permanent teeth, accidentally injured or diseased teeth, and that the denture or bridgework includes the replacement of teeth so extracted while covered by the Plan.

Replacement or alteration and/or the addition of a tooth or teeth to an existing removable denture (full or partial) or fixed bridgework, but only if evidence satisfactory to the Fund is presented that:

1. the replacement or addition of a tooth or teeth is required because of the extraction of one or more natural teeth while eligible for Plan benefits;
2. the existing denture was installed five (5) years or bridgework was installed at least seven (7) years prior to the replacement and cannot be made serviceable due to natural structural changes in the mouth;
3. the existing denture or bridgework cannot be made serviceable due to structural changes in the mouth resulting from oral surgery involving muscles and tissues or from accidental injury, but only if replacement or alteration is provided within 12 months following the surgery or accident.

Rebasing or relining of a denture, if done more than six (6) months from the date of the initial placement but not more than once in any two-year period.

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DENTAL PLAN INFORMATION CARD

Group No. TM856

**Plan Administrator: Associated Third Party
Administrators**

www.firstdentalhealth.com

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For information on eligibility, benefits and claims, please
contact Associated Third Party Administrators at
(800) 297-4595 or at (415) 547-3617.

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San Diego CA 92191**

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