Since Benefit Coverage changes periodically, this part of the descriptive booklet has been prepared as a removable insert. It may, therefore, be amended without having to revise the entire booklet.

There are three sections of coverage: Basic, Major and Orthodontic. The allowances for Benefit payments, under the Basic and Major sections are derived from a fee guide published, annually, by the Ontario Dental Association ("ODA"). Therefore, the Trustees make an annual determination about the Trust Fund's financial ability to keep pace with the latest version of the ODA fees.

All claim settlements are based on the version of the ODA fee guide used by The Plan, when the claim was incurred. Effective February 1, 2023, the Plan will adopt the 2023 ODA Fee Guide. However, there is no compulsion for Dentists to adhere to a particular version of the ODA fee guide, so charges may vary from the allowances provided by The Plan. If the Dentist's charges exceed The Plan's allowances, then the Plan Member is personally responsible for the difference.

There is no official fee guide for Orthodontic treatment. Consequently the Trustees set Coverage allowances which are both affordable for The Fund, and helpful in offsetting the current charges for Orthodontic care.

Effective for claims incurred in 2023, the combined annual plan maximum for routine and major care will be increased from $2,000 to $2,500 per person and the maximum for orthodontia will increase from $2,500 to $2,700 per lifetime, per person.

Type Of Expense	Reimbursement Allowances
Basic*	95%
Major*	85%
Orthodontic*	60%
Basic/Major Maximum Amount Per Calendar Year	$2,500.00
Orthodontic Lifetime Maximum Amount	$2,700.00

**The percentages of reimbursement, shown above for Basic, Major and/or Orthodontic treatments, may be increased to 100% of the expenses (normally recognized by The Plan) for damage to teeth and/or dental work resulting from an accident, if it is not self-inflicted.*

Any series of treatment expected to cost more than $300.00 should be described by the attending dentists as a treatment plan, and submitted to the Administrator for assessment and Pre-authorization before the treatment begins. (This is particularly important in the case of crowns, bridgework, standard dentures and alternate to implants.) All requests for Pre-authorization will be answered by the Administrator with a confirmation of the Benefit payment to be made including alternate procedures, if applicable, and the return of information or materials submitted.

BASIC DENTAL SERVICES

The following list indicates all of the services that are classified as covered Basic procedures, along with applicable limitations.

- Once every nine (9) consecutive months (six (6) months for dependent children twelve (12) years of age and under): a recall exam; cleaning; polishing, up to four (4) bite-wing x-rays; scaling in combination with root planing under Major services, to a maximum of ten (10) units per calendar year; and, if the person is under nineteen (19) years of age, the application of fluoride solutions, done in the Dentist's office. (For children under twelve (12) years of age, the flouride application may be performed once every six (6) months.)
- CBCT Scan once every twenty-four (24) months.
- Once every thirty-six (36) months a complete oral examination, including a full mouth x-ray, for the establishment of records with a new Dentist.
- During or following from, a recall visit, or on an emergency basis:
    - fillings with silicate, acrylic, composite, amalgam or bonded amalgam;
    - replacement of existing fillings, which have failed more at more than twenty-four (24) months after their placement;
    - occlusal x-rays, at the rate of four (4) per twelve (12) month period;
    - extractions;
    - root canal;
    - conscious sedations in relation to other covered treatments;
    - general anaesthetic for surgery and for eligible proceedures when recommended by a Dentist;
    - repair or re-cementing of crowns, inlays, bridgework, or dentures;
    - adding teeth to existing dentures;
    - relining or rebasing dentures (provided The Plan is not paying for new dentures, as well);
    - intravenous or intra-muscular antibiotic medication and its administration in the Dentist's office, or outside the Dentist's office if prescribed by the attending Dentist;
    - space maintainers as replacement of the missing primary teeth of Children under fourteen (14) years of age;
    - pit and fissure sealants, for persons under nineteen (19) years of age;
    - finishing of restorations by polishing fillings, removing overhangs or refining marginal ridges – provided the restorations are two (2) or more years old, or they were originally done by a Dentist other than the one performing the refinishing work (a lab receipt must be provided); and,
    - laboratory tests ordered by the attending Dentist;
- Emergency treatment.

MAJOR DENTAL SERVICES

The following list indicates all of the services that are classified as covered Major procedures, along with applicable limitations. (Pre-authorization, as noted in item 2.02(ii) of this booklet, is strongly recommended in relation to Major services, whether or not the expected cost is more than $300.00)

- Extensive restorations of permanent teeth such as crowns, inlays, onlays, and fixed bridgework including posts and cores upon approval if: (i) the tooth/teeth cannot be restored in any other way; and, (ii) the restoration is not replacing an identical one provided by The Plan during the prior five (5) years.
  Note: Reimbursement is limited to the maximum Benefit allowance for a permanent crown when charges are being claimed for both a temporary and permanent crown. (Permanent crown must be placed within twelve (12) months.)
- Periodontic treatment of the gums and supporting structures of the teeth, including root planing of up to ten (10) units per calendar year.
  Note: Root planing under Major services and scaling under Basic services, have a combined maximum of ten (10) units per calendar year, to be used at the discretion of the Plan Member, but no more than ten (10) units in total.
- Appliance for Bruxism, once per twenty-four (24) months.
- Endodontic treatment, other than root canals.
- Complete or partial standard dentures, provided they are not replacing ones that: (i) can be satisfactorily repaired or relined; or, (ii) were purchased by The Plan during the previous five (5) years.
  Note: Reimbursement is limited to: the maximum Benefit allowance for a permanent denture when charges are being claimed for both an immediate, temporary denture; and, to the allowance for Standard Dentures, as specified in the ODA fee guide currently used by The Plan. (Permanent denture must be placed within twelve (12) months and, the cost of the temporary denture will be deducted from the eligible payment.)
- Fractures, dislocations and other necessary oral surgery other than the extraction of impacted teeth (which is covered under Basic services).
- Veneer application, once every five (5) years.
- Reasonable and customary laboratory charges in relation to a covered proceedure. A copy of the laboratory bill indicating the breakdown of charges required.

Note: All claims for Major Dental Services are settled in accordance with the version of the ODA's fee guide used, by The Plan, when the related expense was incurred.

ORTHODONTIC SERVICES

Orthodontic services consist of treatment or surgery provided by a certified orthodontist or Dentist for the purpose of correcting malaposed teeth.

The orthodontist will perform a diagnostic examination to determine the nature and the extent of the required treatment. From that diagnostic examination, the related patient records will be prepared and the initial and ongoing fees will be specified by the orthodontist. Plan Members should consider those fees in relation to the following schedule of benefits, and understand that the procedures must be pre-approved by the Administrator. Then, reimbursement will be made only after the treatment has taken place.

Please remember that effective February 1 2023, the overall lifetime maximum is $2,700.00 per person.

SCHEDULE OF ORTHODONTIC BENEFITS PROCEDURES

Procedures	Benefit
Diagnostic examination (including the full initial visit and preparation of patient records)	60% of the related fee, to a maximum reimbursement of $240
Initial treatment (when the device is installed)	60% of the related fee to a maximum reimbursement of $1,200
Subsequent treatments	Balance of the cost will be equally spread out monthly for the duration of the treatment. Monthly claim forms and receipts of payment must be submitted confirming ongoing treatment and payment.

The clinical description of condition, treatment length and payment plan must be provided.

Balance of orthodontic treatment cost to be divided over the number of months noted in the treatment plan.

Note: Reimbursement will be made only in accordance with the foregoing schedule. Full payment will not be made in advance.

Note: Reimbursement will be considered for ongoing orthodontic expenses in cases where the series of treatments began before the Plan Member satisfied the Requirements For Eligibility. However, such consideration will apply only to expenses incurred after the Employee became a Plan Member.

SERVICES NOT COVERED BY THE PLAN

The following list specifies services and supplies that are not covered by The Plan Any doubt about applicable Coverage should always be reviewed with the Administrator. No other party is authorized to confirm Coverage for Plan Members.

- The expenses, for any services or supplies, incurred while the Plan Member or Dependant is not eligible for Coverage.

Note: The complexity of this point is illustrated by the methods of determining when a service begins. For example: root canal therapy begins when the tooth is opened; orthodontic treatment begins when an active appliance is first placed on the teeth; the commitment for complete or partial dentures is made when the final impression is taken; and, the application of bridgework and crowns begin with the preparation of one tooth.

- No Coverage recognition is given for any of the items named below.
  - Chlorhexidine varnish treatment.
  - Cosmetic treatment.
  - Temporomandibular joint muscle dysfunction procedures.
  - Facings on crowns or on pontics (false teeth) in back of the second bicuspid.
  - Periodontal splinting and ligation.
  - Implants and/or implant surgery
  - Treatment other than by a licensed physician, dentist. dental auxiliary, denture therapist or hygenist.
  - Charges for writing prescriptions, duplicating records, or preparing reports.
  - Appliances to increase vertical occlusal dimension.
  - Mouthguards, except as listed on page 3, under Major Dental Services.
  - Crowns and restorations except those listed on page 3, Major Dental Services.
  - House calls.
  - Training and supplies used for personal oral hygiene or dietary or nutritional counseling.
  - Professional consultations (profession to profession).
  - Plaque control programs.
  - Extra charges for office visits during abnormal hours.
  - Any services and supplies payable under any provincial medical, dental, or hospital insurance plan, any provincial workers compensation agency (i.e. WSIB in Ontario), or by any public or tax-supported agency.
  - Services for which no charge would be made if The Plan did not exist (i.e. a charge for completing the claim form).
  - Any services and supplies paid, or payable, under any other plan to which the employer contributed, or for which the employer made payroll deduction.
  - Services or supplies required as the result of any intentionally self-inflicted injury, criminal activity or as the direct result of war (declared or undeclared), or from participation in a riot or insurrection.
  - Any charge made for a missed appointment.
  - Dentures which have been lost, mislaid, or stolen, unless the denture was at least five (5) years old at the time it was lost, mislaid, or stolen, or unless The Plan had not paid for it during the past five (5) years.

UNITED FOOD AND COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN – ONTARIO

DETAILS OF THE COVERAGES AS AT FEBRUARY 1 2023

Note: This is not a complete description of the Plan. Rather, it outlines the Coverage that may change from time to time, whereas the operating rules are presented in the main body of the booklet to which this is an insert. *Therefore, please ensure that you are in possession of a current copy of the insert.*

UNITED FOOD AND COMMERCIAL WORKERS

TRUSTEED DENTAL PLAN – ONTARIO

Your Dental-care Coverage Handbook

For ease of communication throughout this booklet, the United Food And Commercial Workers Trusteed Dental Plan – Ontario is simply called The Plan.

Assistance

Members of The Plan should always direct questions about their Coverage to the Administrator.

Write to: The Administrator
United Food and Commercial Workers
Trusteed Dental Plan – Ontario
Suite 110, 61 International Blvd.
Toronto, ON
M9W 6K4

Or call: 1-800-461-4361
416-674-3350 *(in Toronto)*

Fax: 416-674-1525

Privacy guidelines require Plan Members to verify their identity, with their full name, social insurance number, home address and telephone number, before discussing sensitive personal matters with the Administrator.

Purpose Of This Booklet

This booklet is a reference to the rules of The Plan, and a quick guide to the Benefits it covers. The information that is most essential for Plan Members is presented herein, but final interpretations on all matters must be taken from the official Plan Text. **No rights, contractual or otherwise, are created or conferred by this booklet, and the Board Of Trustees reserves the full authority for final interpretation and adjudication.**

The information that is most essential for Plan Members is presented herein.

It is important that Plan Members and their families read this booklet before dental treatment is begun. By doing so, disappointment may be avoided over matters like Coverage entitlement, the timing and extent of treatment and the submission of claims. Remember, however, that requests for clarification **should be directed to the Administrator.**

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Operation Of The Plan

The Plan is financed from a Trust Fund into which employer Contributions are made. The amounts and the timings of those Contributions are specified in Collective Agreements between the Union and the Participating Employers. In turn, the records of Contributions are the basis upon which Employees become Plan Members.

Both the Trust Fund and The Plan are governed by a Board Of Trustees. The Members of that Board (the"Board Of Trustees") are appointed by the United Food and Commercial Workers Canada, Locals 175 & 633, and by representative employers – four from each side. The Board Of Trustees controls every aspect of the Trust Fund and The Plan operations.

The provisions of The Plan (both rules and Coverage) have been established by the Board Of Trustees, who also amend those provisions in keeping with the general changes to dental services, and with the financial well-being of the Trust Fund.

Registration To Participate

Certain basic information is needed to identify each Plan Member, so that records and entitlements are not confused. Therefore, everyone is asked to complete a Registration Card for submission to the Administrator. It includes the Plan Member's name, date of birth, social insurance number, contact information, Dependant identifications, and authorization to use the data in prescribed ways.

Everyone is asked to complete a Registration Form

Change in any part of a Plan Member's basic information should be sent to the Administrator using a Registration Card which may be obtained from the Administrator, the Union, or a Participating Employer.

Everyone has the right to refuse to disclose personal information, or to withdraw it from use by The Plan. Doing either of those things, however, may hamper or preclude the payment of Benefits for the Plan Member who chooses that option, and/or the related Dependants. Therefore, the consequences of refusal or revocation of personal information should be understood before either action is taken.

Protection Of Personal Information

Personal information on Plan Members and their Dependants is stored with the utmost attention to security. As well, it is used carefully and sparingly to fulfill only the requirements of The Plan and related laws.

Dissatisfaction with the storage or use of personal information should be reported to the Administrator. If that proves to be unsatisfactory, the Plan Member should write to the Board Of Trustees, or with the appropriate outside authority.

DEFINITION OF TERMS

Where the following terms are capitalized, throughout this booklet, they are intended to have the meanings defined below.

Absence From Work Form means a document that must be completed by the Participating Employer verifying that the Plan Member is on an approved leave of absence, or is laid off, or is not scheduled to work, or has retired.

Administrator means the organization chosen by the Board Of Trustees to carry on the day-to-day business of The Plan. For example, the Administrator will answer questions from Plan Members and process Benefit claims.

Benefit(s) means the dental services and supplies covered by The Plan. Details of those Benefits are provided throughout this booklet.

Board Of Trustees means the group of people chosen in equal number by the Union and by Participating Employers to govern the affairs of the Trust Fund and The Plan. They have complete and absolute authority in all related matters.

Collective Agreement means a collective agreement, or other agreement, acceptable to the Board Of Trustees, in which an employer agrees to make Contributions to The Fund.

Contribution(s) means the amount of money that must be paid to The Fund, either by a Participating Employer or by a Plan Member making Self-payments.

DEFINITION OF TERMS

Coverage means the assurance extended to Plan Members that expenses, incurred by them and/or their Dependants for the treatment of certain procedures listed in the Ontario Dental Association ("ODA") Fee Guide, will be reimbursed from the Trust Fund according to the terms of The Plan. (The version of the ODA Fee Guide is changed periodically by the Trustees, so consultation with the Administrator is recommended.)

Dentist means a person qualified to practice dentistry under the laws and regulations of the territorial jurisdiction in which dental services and supplies are provided or prescribed for any Plan Member or Dependant.

Dependant(s) means the spouse and unmarried, dependent children of a Plan Member, as further defined below.

- **Spouse means** a person who is legally married to the Plan Member, or who has cohabited with the Plan Member, in a common-law or other marriage-like relationship for at least one year. If the Plan Member has more than one Spouse, only the person named as such on the Registration Card will be covered by The Plan.

[**Note: Proof of common-law or other like relationship is required.**]

- **Dependent Child** means the Plan Member's natural, adopted or step child, who has not reached age 19, or has not reached age 25 while being enrolled in School as a full-time student, or is age 19 or over and is incapable of self-sustaining employment because of mental or physical disability.

[**Note: Proof of full-time enrolment in School is required.**]

DEFINITION OF TERMS

Employee(s) means a person, or persons, employed by a Participating Employer, under the terms of a Collective Agreement, as further defined below.

- **Full-time Employee(s)** means an Employee, or Employees, whose employment condition(s) is/are defined, in part, under the terms of the related Collective Agreement, as being full-time.
- **Part-time Employee(s)** means an Employee, or Employees, whose employment condition(s) is/are defined, in part, under the terms of the related Collective Agreement, as being part-time.

Plan Member or Member means an Employee who has satisfied the Requirements For Eligibility.

Participating Employer means an employer who, as party to a Collective Agreement, is committed to make Contributions on behalf of Employees.

Plan means the body of rules, regulations, and provisions that define the Coverage and explain a Plan Member's entitlement to Benefits. Those rules, regulations, and provisions are contained in a document called the Plan Text.

Registration Card means a document, approved for use by the Board Of Trustees, on which each Plan Member must record the personal information needed for identification and the provision of entitlements under The Plan. (It must be completed, executed, and filed with the Administrator before Benefit payments can be made).

DEFINITION OF TERMS

Self-Payment(s) means the making of Contributions by a Plan Member, under the rules of The Plan.

School means an institution that provides education, at the secondary or post-secondary level, of the types approved for general, public application within the jurisdiction of the government authority responsible for the particular school and/or school district.

Trust Fund means the legal entity into which Contributions are made, and from which the operations of The Plan are financed under the jurisdiction of the Board of Trustees.

Trustees mean the people who compose the Board Of Trustees.

Union means the United Food and Commercial Workers Canada, including its affiliates and special divisions.

Requirements For Eligibility

The following conditions that must be met before an Employee becomes a Plan Member and, therefore, is entitled to Coverage.

- **Full-time Employees** must:
  - (i) be classified for full-time employment under the terms of the Collective Agreement pertaining to their employment;
  - (ii) have been employed for ninety (90) consecutive days commencing from, or after, the date at which their employer became a Participating Employer; and,
  - (iii) have had Contributions made, continuously on their behalf, for all of their employment time on, and after, the date at which their employer became a Participating Employer.
- **Part-time Employees** must:
  - (i) be classified for part-time employment under the terms of the Collective Agreement pertaining to their employment;
  - (ii) have been employed for one-hundred and eighty (180) consecutive days from, or after, the date at which their employer became a Participating Employer; and,
  - (iii) have had Contributions made, continuously, on their behalf, for all of their employment time on, or after, the date at which their employer became a Participating Employer.

Exception: Coverage, for both Full-time and Part-time Employees, begins on the date at which their employer becomes a Participating Employer if, immediately prior to that date, they had comparable dental-care coverage sponsored by that employer. However, Employees of the same organization, hired after the date at which their employer became a Participating Employer, must fulfil the ninety (90) and one-hundred and eighty (180) consecutive day requirements, noted above.

The Employee must have completed a Registration Card, which has been submitted to the Administrator. (Registration Cards are available from the Administrator, the Participating Employer, or the Union office.)

Regardless of the other Requirements For Eligibility, no Benefits will be paid until the Registration Card is received and accepted by the Administrator.

Details Of Coverage

1.01 Who is eligible for Coverage?

Any person who satisfies the Requirements For Eligibility stated on page 5 of this booklet.

1.02 When does Coverage begin?

Coverage begins on the first day of the calendar month following the date on which the Plan Member satisfied the Requirements For Eligibility.

For the Dependants' of a Plan Member, Coverage begins on the same date that the Plan Member gains Coverage, provided the Plan Member is classified as a Full-time Employee. However, if the Plan Member is classified as a Part-time Employee, the Dependants' Coverage begins on the first day of January following a twelve-month period, ending the prior September 30th, during which one or more Participating Employers have made Contributions, for the Plan Member, in relation to at least 1,100 hours of employment.

Note: The Dependants' Coverage, described above, in relation to Part-time Employees, applies for one calendar year each time the 1,100-hour qualifier is satisfied.

1.03 What happens to Dependants' Coverage when the Plan Member's employment classification changes?

If the Plan Member's employment classification changes from Full-time to Part-time, Dependants' Coverage will cease at the end of the month in which the classification changed, unless the Plan Member had satisfied the 1,100-hour rule for current Dependants' Coverage.

If the Plan Member's employment classification changes from Part-time to Full-time, Dependants' Coverage will commence the first day of the month following the date on which the classification changed, if such Coverage was not previously in effect. Otherwise, Dependants' Coverage will continue without interruption.

Note: The foregoing explanations presuppose that the Requirements For Eligibility continue to be satisfied throughout the period when the employment classification is changed.

1.04 How does the Employee know that Plan Member status and Dependants' Coverage have been gained?

The Administrator will notify the Employee in writing.

Note: Notification will be provided only if the Plan Member's mailing information has been given to the Administrator via the filing of a Registration Card.

1.05 Is Coverage continued during periods of maternity or parental leave?

Coverage is continued during periods of maternity and parental leave exactly in accordance with provincial law, provided such Coverage was in effect immediately prior to the commencement of that leave. That applies to both the Member's and the Dependants' Coverage.

If Coverage – either the Member's or Dependants' – was not in effect at the commencement of either maternity or parental leave, then Coverage will begin at the time it would otherwise have if the leave had not occurred.

Note: In order to avoid confusion, the Plan Member should advise the Administrator that maternity or parental leave is about to begin as at a specific date.

1.06 Is Coverage continued during periods of disability which prevent the Plan Member from working?

Yes. Coverage is continued for up to twelve (12) months during any one continuous period of disability which prevents the Plan Member from working.

Such Coverage is intended to run from the first day of the calendar month following the onset of disability, if the Plan Member's employer reports the situation, in writing, to the Administrator.

One continuous period of disability (as referenced above) means: an uninterrupted absence from work; or two or more absences from work, due to the same cause, provided the multiple absences are separated by temporary return(s) to work of less than thirty (30) consecutive days. After one continuous period of disability has lasted twelve (12) months, the Plan Member may maintain Coverage, for up to thirty-six (36) additional months, by making Self-payments.

1.07 Is Coverage continued during periods of temporary lay-off or approved leave of absence?

Coverage may be continued for up to thirty-six (36) months, during periods of either temporary lay-off or approved leave of absence, if the Plan Member chooses to make Self-payments. Such Self-payments must be made for the period beginning at the first day of the calendar month immediately following the commencement of temporary lay-off or approved leave of absence, and must be continued without interruption for the desired period of Coverage.

Note: The Participating Employer must advise the Administrator, in writing, prior to the commencement of temporary lay-off or leave of absence, by identifying the Plan Member and specifying the date at which the event will occur, by completing the Absence From Work Form. This Form can be obtained from the Administrator or The Plan's website.

1.08 Can Coverage be continued after retirement?

Plan Members who retire before reaching sixty-five (65) years of age, may choose to continue their Coverage up to the end of the calendar month in which their sixty-fifth (65th) birthday occurs.

This extended Coverage must be supported by Self-payments. The first of such payments must be made for the month immediately following the date of retirement. If the Self-payments lapse, prior to the Plan Member's 65th birthday, Coverage will terminate at the end of the calendar month for which the last of such payments was made.

Note: If the Plan Member wishes to extend Coverage beyond the date of retirement, the Participating Employer must confirm, in writing to the Administrator, that the Employee is retiring as at a specific date.

1.09 Is Coverage continued for the Dependants of Plan Members who choose to make Self-payments?

Yes. Coverage is continued for the Dependants of Plan Members who choose to make Self-payments, provided such Coverage was in place, immediately prior to the commencement of the Self-payments, and provided the Dependant(s) continue to satisfy all of the other Plan rules.

1.10 How are Self-payments to be made?

Self-payments (as defined in items 1.06, 1.07 and 1.08) are to be made, to the Administrator, by cheque or money order made payable to the United Food and Commercial Workers Trusteed Dental Fund – Ontario.

During any period of Self-payment, the first payment must reach the Administrator, on or before the later of the fifteenth (15th) day of the calendar month to which the payment applies, or the fifteenth (15th) day following the receipt of the Administrator's advisory that the Self-payments may be made.

Second and subsequent Self-payments must reach the Administrator on or before the fifteenth (15th) day of the calendar month to which the payment applies. Otherwise, the Self-payment privilege may be withdrawn.

The first Self-payment must be accompanied by the Absence From Work Form, from the Participating Employer, verifying that the Plan Member is on approved leave of absence, or is laid off, or is not scheduled to work, or has retired. If the Plan Member is disabled, the Participating Employer must advise the Administrator directly.

1.11 May Self-payments be stopped and, then, started again at the discretion of the Plan Member?

No. If a Plan Member stops making Self-payments during any period for which he/she has qualified to do so, the option to make such payments is irrevocably lost for the remainder of that period.

1.12 How much are the Self-payments?

The amount of the Self-payment changes from time to time, based on the operating costs of the Trust Fund and The Plan.

1.13 Why and when does Coverage terminate?

Coverage terminates for several different reasons, as indicated below.

The Plan Member's Coverage terminates:

(i) immediately upon death, or at the date that the Plan Member's employer withdraws from participation in The Plan, or, at the date on which The Plan ceases operations;

(ii) at the end of the calendar month in which the Plan Member's employment is terminated, other than by retirement;

(iii) at the end of the calendar month in which the Plan Member retires, is laid off, is not scheduled to work, or commences an approved leave of absence other than for maternity or parental leave, or, has been on disability leave for 365 days – unless the Plan Member was entitled to make Self-payments and elected to do so; or,

(iv) at the end of the last calendar month for which Self-payments were made, if the Plan Member does not otherwise qualify for Coverage continuance.

The Dependants' Coverage terminates:

(i) at the last day of the calendar month in which the Coverage of the related Plan Member ceases; or,

(ii) at the last day of the calendar month in which a Dependant ceases to qualify as a Dependant under the rules of The Plan; or,

(iii) at December 31st following the qualifying period (October 1st through September 30th) in which a Part-time employee failed to satisfy the test for Dependants' Coverage (see item 1.02); or,

(iv) at the end of six-months following the month in which the Plan Member dies.

Note: Item 2.09 explains the circumstances in which benefits may be paid for a particular course of treatment after Coverage has terminated.

1.14 Is Coverage continued during a work stoppage caused by a labour dispute?

Yes. Coverage is continued for up to thirty-one (31) days following the commencement of a strike or lockout, for the affected Plan Members and Dependants who had Coverage immediately prior to that commencement date.

If Coverage, for either the Plan Member or Dependants, was not in effect immediately prior to the commencement of a strike or lockout, such Coverage will begin on the later of:

(i) the date, after the strike or lockout is settled and the Employees return to work; or,

(ii) the date, after the strike or lockout is settled, at which the Coverage would normally have begun, had the labour dispute not occurred, it being understood that the term of the strike or lockout will be treated as employment time in fulfilling the Requirements For Eligibility.

1.15 How may Coverage be re-established after it has been terminated?

Coverage that was terminated, because of lay-off, leave of absence, disability, or lack of scheduled work, will be re-established on the first day of the calendar month following the completion of ninety (90) consecutive days of employment with a Participating Employer, regardless of Full-time or Part-time employment status, provided Contributions are remitted during this time.

Otherwise, the Requirements for Eligibility must be satisfied.

1.16 What Coverage is provided for Dependants of a deceased Plan Member?

Coverage is extended, to the Dependants of a deceased Plan Member, through the end of the month in which the death occurred, plus six (6) calendar months. Such extended Coverage applies to the people who were qualified Dependants at the time of the Plan Member's death, and who continue to satisfy the Requirements For Eligibility during the extension period.

Should a Dependant stop satisfying the Requirements For Eligibility during the extended period of Coverage, the Coverage of the particular Dependant will cease at the end of the calendar month in which such stoppage occurs. Such an event will not impair the extended Coverage of the other Dependants.

Claims Making & Related Matters

2.01 How are claims for benefits to be made?

Plan Members, as the primary covered persons, are to make benefit claims for themselves and their Dependants.

The claim form, that must be used, has been standardized by the Canadian Dental Association and, therefore, it is available throughout Canada. It is most easily secured from the attending Dentist who must complete the portion titled 'PART I'. Otherwise the Plan Member should follow the instructions on the claim form, for the remainder of its completion. Then, it must be submitted to the Administrator for the processing that leads to claims payment.

Note: A separate claim form must be completed and submitted to the Administrator for each family member who has incurred dental expenses.

Note: Claim forms may be downloaded from this website, secured from the Administrator, the Union, or a Participating Employer, as well as a Dentist.

2.02 Are there circumstances in which the claim form alone may not justify a payment of Benefits?

Yes. There are circumstances in which the claim form must be supplemented, such as:

(i) when a claim is submitted on behalf of a Plan Member's child, aged nineteen (19) years or older, it must be established that the child is mentally or physically disabled, or is enrolled in full-time attendance at School; or,

(ii) when a course of dental services (including dentures and other appliances, or laboratory work) is expected to cost more than $300.00, a Dentist's treatment plan must be sent to the Administrator for assessment and pre-authorization; or,

(iii) when pre-authorization is needed for crowns, bridgework, or orthodontic treatment, the related x-rays and laboratory bills must be released to the Administrator.

Note: All requests for pre-authorization will be answered by the Administrator with a confirmation of the Benefit payment(s) to be made and with the return of information, and/or materials submitted.

Claims Making & Related Matters

2.03 Could a Plan Member be penalized for the submission of inaccurate or misleading information?

Claim information is expected to be clear and accurate, and to be presented as an honest representation of the facts. The Board Of Trustees reserves the right to reject any claim in relation to which a deliberate attempt has been made to falsify any of the related information.

2.04 Is there a time limit on the submission of claims?

Yes. Claims must be submitted, for payment, within twelve (12) months of the date on which the expense was incurred.

2.05 Can the Plan Member choose any Dentist to provide services?

Yes.

2.06 Can a Plan Member and his/her Spouse claim twice for the same expenses, if they are both Plan Members?

Yes, they can do so, but the combined amount of reimbursement cannot exceed 100% of the expenses that are normally covered by The Plan. The Plan Member who incurred the expense claims first and, then, any unpaid portion may be submitted by the Plan Member/Spouse for additional reimbursement.

Note: If claim forms are signed by both Plan Members and submitted with the initial claim, the Administrator will make the complete reimbursement in one transaction.

2.07 Where should claims be submitted first, if a Plan Member's Spouse participates in another dental plan?

The Plan Member who incurred the expenses must claim first, against their own plan. Then if full reimbursement is not made by that plan, the unpaid amount may be claimed from the other Spouses's / Plan Member's plan.

Note: In the case of dental expenses for a Dependent Child, the claim should be submitted first to the dental plan under which the parent, with the earliest birth date in the calendar year, participates. (That does not mean the younger of the parents, but rather the birth date coming first in the calendar year). Any amount of dental expense not reimbursed in that first submission, should then be claimed against the other parent's plan.

Note: These procedures, commonly called 'coordination of benefits', have become a standard practice whereby different dental care plans can interact to maximize benefit reimbursements. It is necessary, therefore, that claim records produced by the first payer be shared, or coordinated with, the second payer. The Plan Member must provide and exchange the required documentation.

2.08 Can The Plan help, in any way, if a claim payment from a provincial workers compensation agency (the "PWCA") [i.e. the Workplace Safety and Insurance Board, in Ontario] is unduly delayed?

Yes. If a claim payment has been delayed for more than forty (40) days since it was first submitted to a PWCA, The Plan may offer a temporary payment, provided all of the following conditions are fulfilled.

- The PWCA forms were fully completed when they were first submitted.
- Some, or all, of the dental services, upon which the PWCA payment is based, are identical to those normally covered by The Plan.
- Complete copies of claim forms, sent to the PWCA, are submitted to the Administrator.
- An assignment (provided by the Administrator) is executed by the Plan Member and returned to the Administrator, whereby the Plan Member's entitlement from the PWCA will be paid to The Plan in an amount equal to the temporary payment advanced by The Plan. The amount of the temporary payment, advanced by The Plan, will equal the lesser of the Plan Member's entitlement from the PWCA and the amount that The Plan would normally reimburse for the specified services and/or supplies.

2.09 Might reimbursement be made for dental expenses incurred after the termination of Coverage, if the related series of treatments commenced before the Coverage-termination date?

Yes. Coverage is extended, for up to 90 days following its official termination, in the particular circumstances specified below.

- Fixed bridgework, crowns, inlays, or onlays are being provided, and the tooth was prepared while the affected person was covered by The Plan.
- Complete or partial dentures are being provided, and the final impression for the appliance was taken while the affected person was covered by The Plan.
- Endodontic treatment is being provided and the tooth was opened for root canal therapy while the affected person was covered by The Plan.
- Injury to natural teeth which occurred while the affected person was covered and, as a result of which that person is totally disabled, through the date on which the Coverage terminates.
- Orthodontic treatment is being provided, and appliances were placed on the teeth while the affected person was covered by The Plan.

Claims Making & Related Matters

2.10 To whom are claim reimbursements made?

All claim reimbursements are made to the Plan Member, regardless of the family member for whom the expense was incurred. Also it is important to understand that Benefits cannot be assigned to a Dentist.

2.11 How long should it take for claim reimbursement to be made?

Every effort will be made to issue claim reimbursement within three (3) business days from the date on which a complete, accurate claim form is received by the Administrator. Return postal time must, of course, be added to that 3-day period.

2.12 Does The Plan offer direct deposit to a personal bank account for Benefit payment?

Yes. Benefit payments can be deposited directly to a bank account. The Plan Member should contact the Administrator or visit The Plan website for the appropriate form.

2.13 Can a Plan Member appeal a settlement decision taken in relation to claims for themselves and their Dependants?

Yes, they can. Such appeals must be made in writing to the Appeals Committee of the Board Of Trustees, in care of the Administrator. Each appeal must identify: the claimant; the person for whom the expense was incurred; the details of the settlement decision; and, the reason for disputing the decision.

Every claim appeal is reviewed by the Board Of Trustees, whose final ruling is communicated to the appellant and acted upon by the Administrator.

2.14 Does The Plan have an e-mail address?

Yes, but only for the submission of claims and the direct deposit form. The e-mail address is **theontariodentalplan@pbas.ca.** There will be no reply to your e-mail.

2.15 Where should claims be submitted?

Claims can be submitted as follows:

BY MAIL: The Administrator, UFCW Trusteed Dental Plan – Ontario
61 International Blvd., Suite 110
Toronto, ON M9W 6K4

BY FAX: 416 674 1525

BY E-MAIL: **theontariodentalplan@pbas.ca**

Tax Considerations

3.01 Are claim reimbursements/Benefit payments subject to income tax?

No.

3.02 Can any portion of the dental care expenses be used as an income tax deduction?

Yes, as at the date of publishing this Booklet, dental care expenses, for which Benefit reimbursement is not made, can be used in computing a medical expense deduction from taxable income.

Please visit The Plan website for additional information.

NOTES:

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