

## **DENTAL BENEFITS**

### **Benefit Schedule**

All expenses will be reimbursed at the level shown in the Dental Care Options below, as elected at the time of application.

### **Dental Care Option 1**

Basic Care 60%, Major Care 50% to a combined maximum per Insured per Policy Year of \$2,000 and Orthodontics 50% to a lifetime Maximum of \$2,000.

### **Dental Care Option 2**

Basic Care 80%, Major Care 50% to a combined maximum per Insured per Policy Year of \$2,000 and Orthodontics 50% to a lifetime Maximum of \$2,000.

Reimbursement is based on Reasonable and Customary charges in the area that the expense was incurred.

### **Eligibility**

All primary Insured members, their spouses and eligible Dependent children (as defined by this policy) are eligible for Dental coverage.

### **Basic Care: Diagnostic Services**

1. One complete oral examination every three years;
2. Oral pathology, periodontal, surgical, prosthodontic, and endodontic examinations;
3. Limited oral examinations once every nine months except that only one limited oral examination is covered in any year that a

complete oral examination is also performed;

4. Non-Emergency bite wing radiographs, once every nine months;
5. Limited periodontal examinations once every six months;
6. Specific and Emergency examinations (including bite wing and intra-oral radiographs);
7. Complete series of intra-oral radiographs (non-Emergency), once every 36 months;
8. Panoramic radiographs once every 24 months. Services provided in the same year as a complete series are not covered;
9. Sialography;
10. Extra-oral radiographs other than panoramic and sialography;
11. Radiopaque dyes used to demonstrate lesions;
12. Interpretation of radiographs or models from another source;
13. Microbiological, histological, cytological, and pulp vitality tests;
14. Laboratory reports.

**Basic Care: Preventative Services**

1. Polishing or prophylaxis once every six months for Dependent children and once every nine months for adults;
2. Scaling and root planning – six time units a year;
3. Topical application of fluoride once every six months for Dependent children and once every nine months for adults;

4. Oral hygiene instruction once in an Insured Person's lifetime;
5. Pit and fissure sealant on bicuspid and permanent molars, once every five years for Dependent children only;
6. Space maintainers;
7. Maintenance of space maintainers;
8. Finishing restorations;
9. Interproximal diskings;
10. Recontouring of teeth.

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval. Each incident of services is considered 1 time unit, regardless of its duration.

No benefit will be paid for:

1. Custom fluoride appliances;
2. Audio-visual oral hygiene instruction; or,
3. Nutritional counseling;
4. Whitening treatments.

**Basic Care: Minor Restorative Services**

1. Caries, trauma, and pain control;
2. Amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least three years old or the existing filling was not covered under this plan;
3. Retentive pins and prefabricated posts for fillings; and,
4. Prefabricated crowns for primary teeth;
5. Periodontics;
6. Endodontics.

**Basic Care: Oral Surgery**

1. Removal of teeth;
2. Surgical exposure of teeth;
3. The following procedures for remodeling and recontouring oral tissues;
4. Minor alveoplasty;
5. Gingivoplasty and stomatoplasty;
6. Surgical incisions;
7. Surgical excisions of tumors, cysts and granulomas;
8. Treatment of fractures, including related bone grafts to the jaw; and,
9. Treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty.

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

No Benefits will be paid for:

1. Implantology, abutments, posts or any implant related retentive devices;
2. Surgical movement of teeth;
3. Services performed to remodel or recontour oral tissues, other than those listed above. Services for remodeling and recontouring oral tissues are covered under major coverage; or,
4. Alveoplasty or gingivoplasty performed in conjunction with extractions.

**Basic Care: Adjunctive Services**

1. Minor remedies for relief of dental pain when provided on an Emergency basis;
2. Therapeutic injections; and,
3. Anesthesia required in relation to covered services. The provision of general anesthetic facilities, equipment, and supplies is covered only when a separate anesthetist is required.

No Benefits will be paid for hypnosis or acupuncture.

**Major Services**

Crowns and onlays are covered when a tooth has extensive structural loss or a fracture that cannot be adequately restored using other procedures. The following crowns and related items are covered:

1. Metal, plastic, porcelain, and ceramic crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns;
2. Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays;
3. Posts, cores, and pins related to covered crowns;
4. Copings related to covered crowns;
5. Repairs to covered tooth-colored materials; and,
6. Removal and recementation of crowns and onlays.

Replacement crowns and onlays are covered when the existing restoration is at least five years old and cannot be made serviceable.

No Benefits will be paid for:

1. Veneers;
2. Recontouring existing crowns;
3. Staining porcelain; or,
4. Inlays, except as provided under alternative Benefits.

If a crown or onlay is provided when a tooth could have been adequately restored using other procedures, alternative Benefits will be provided based on coverage for fillings.

Dentures and bridgework, including overdentures and implant-retained appliances associated with a partial denture, are covered when required to replace one or more teeth extracted while the person was insured for major coverage.

#### **Alternative Benefits**

When more than one Dental Service could provide suitable treatment based on common dental standards, the Insurer will determine the Dental Service on which payment will be based and the expenses that will be included as covered Dental Expenses. An alternate procedure may be considered if it is part of usual and accepted dental work that would produce as adequate as a result. Expenses will not be reimbursed if charges exceed usual and customary of the region. For this reason, the Insurer strongly recommends the use

of Predetermination of Benefits when major dental services are needed, so that You will know in advance what the Benefit plan will cover before any treatment begins.

Replacement appliances are also covered when:

1. The existing appliance is temporary; or,
2. The existing appliance is at least five years old and cannot be made serviceable. If the existing appliance is less than five years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is insured for major coverage as a result of;
  - a. the placement of an initial opposing appliance; or,
  - b. the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

The following denture-related surgical services for remodeling and recontouring oral tissues are covered:

1. Remodeling, excision, removal, reduction, or augmentation of the alveolar bone;
2. Remodeling of the floor of the mouth;
3. Vestibuloplasty;

4. Reconstruction of the alveolar ridge;
5. Extensions of mucous folds; and,
6. Related surgical grafts.

The following services are covered after the three-month post-insertion care period has elapsed:

1. Denture remakes, once every three years;
2. Denture adjustments, once per Policy Year; and,
3. Denture repairs and additions, tissue conditioning and resetting of denture teeth;
4. Repairs to bridgework; and,
5. Removal and recementation of bridgework.
6. Removal of implant-retained prostheses for repair;
7. Reinsertion of implant-retained prostheses.

#### **Orthodontic Services**

Orthodontic expenses must be incurred by a covered Dependent child under the age of 18 years, for the treatment of malocclusion.

## **DENTAL EXCLUSIONS AND LIMITATIONS**

The following expenses are not eligible for reimbursement under this policy:

1. Expenses that private Insurers are not permitted to cover by law;
2. Services or supplies the Insured Person is entitled to without charge by law or for which a charge is made only because the Insured Person has insurance coverage;
3. Services or supplies that do not represent reasonable treatment;
4. Services or suppliers associated with:
  - a. Treatment performed for cosmetic purposes only;
  - b. Congenital defects or developmental malformations in people 19 years of age or over;
  - c. Temporomandibular joint disorders;
  - d. Orthodontia, unless elected at the time of application;
  - e. Myofacial pain.
5. Any Dental expense incurred while covered under the plan but submitted 365 days following the date the expense was incurred or 90 days after the coverage has been terminated, whichever is earlier.

Please refer to the General Exclusions section for additional limitations.