

Welcome to the

FACULTY PART-TIME STUDIES INSTRUCTORS

section for the

British Columbia Institute of Technology (BCIT)



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GENERAL POLICY INFORMATION

The information in this booklet was created on March 6, 2008.

Manulife Financial Benefits

The following benefits are underwritten by Manulife Financial under Group Policy Number 788001:

Effective July 1, 2006 - Extended Health Care, Dental Benefits

The following benefits are underwritten by Manulife Financial under Group Policy Number 788301:

Effective July 1, 2006 - Emergency Travel Assistance

For claims inquiries, contact Manulife Financial at 1-800-575-2200

Important Notes

What this 'e-booklet' is:

This information has been prepared to help you toward a better understanding of your Group Insurance Coverage. It does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in your collective agreement and the group Master Policy/ies issued by The Manufacturers Life Insurance Company. In the event of any variation between the information provided in this website and the provisions of the collective agreement or insurance policy/ies, the collective agreement and insurance policy/ies shall prevail, in that order.

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SUMMARY OF BENEFITS

This summary section is not a complete booklet. It has been prepared to give you an informal outline of the main features of your group insurance plan.

Please access the other sections of your E-booklet for further details, or contact your Human Resources Department.

WAITING PERIOD:

On the first day of the month next following:

- 2 months service if you are hired on or before the 15th of the month
- 3 months service if you are hired after the 15th of the month

EXTENDED HEALTH

Deductible:	\$25 single or family per calendar year
Benefit Percentage:	80% of the first \$1,000 of paid expenses per person; 100% thereafter in any calendar year
Lifetime Maximum:	\$250,000
Hospital:	up to private room
Pay-direct Drugs:	prescriptions by law
Paramedical Services:	Chiropractor, Naturopath or Podiatrist: \$250 per calendar year per specialty Physiotherapist or Massage Therapist: \$500 per calendar year combined Speech Therapist: \$200 per calendar year Acupuncturist: \$100 per calendar year Clinical Psychologist or Counselor: \$500 per calendar year combined
Orthopedic Shoes:	\$400 per adult (\$200 per child) in a calendar year
Orthotics:	\$300 per person in a calendar year
Private Duty Nursing:	\$5,000 in any 3 calendar years
Hearing Aids:	\$400 every 5 calendar years
Vision Care:	\$400 every 24 consecutive months

SUMMARY OF BENEFITS

EMERGENCY TRAVEL (ETA)

Deductible: None
Benefit Percentage: 100%
Lifetime Maximum: Unlimited

DENTAL EXPENSE

Deductible: None
Benefit Percentage: 100% Plan A - Basic Services
65% Plan B - Major Services
60% Plan C – Orthodontics
Maximums: Unlimited for Basic and Major Services
\$2,160 lifetime maximum for Orthodontics
**Recall Exams/Fluoride/
Polishing:** twice per calendar year
Scaling/Root Planing: 16 units per calendar year

GENERAL PROVISIONS

Eligibility

A part-time studies instructor who has at least 50% of the full-time equivalent hours, will become eligible for coverage on the first of the month next following 3 months of service, if hired on or before the 15th of the month, this month will count towards the qualifying period, and if hired after the 15th this will not count towards the three month waiting period.

In order to be eligible for coverage under this plan, you or your dependent must reside in Canada and be eligible for coverage under a provincial health care insurance plan.

When Your Insurance Starts

Your insurance comes into effect on the latest of the following dates if you are actively at work on that date:

- the date you become eligible;
- the date you apply; or
- if Evidence of Insurability is required the date it is approved by the Insurer.

Evidence of Insurability

Evidence of Insurability is required if:

- you apply for insurance more than 31 days after becoming eligible to apply; or
- you reapply after your insurance has terminated due to non-payment of premium.

When Your Insurance Terminates

Your insurance terminates in the event of:

- non-payment of premium;
- a change in your classification to one not insured;
- termination of your employment;
- termination or amendment of the Master Policy;
- your commencing active duty in any armed forces;
- your attainment of the age specified in the Description of Benefits section; or
- your retirement.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your insurance coverages may continue for a period as outlined in the Master Policy, but only if the required premiums are paid.

GENERAL PROVISIONS

Eligible Dependents:

Eligible dependents under this plan shall include:

- Unmarried children who are under age 21, or under age 25 if a full-time student in an accredited school, college, or university. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.
- A child of your spouse provided,
 - i) he/she is also your biological child; or
 - ii) your spouse is living with you and has custody of the child.
- Your spouse, which includes:
 - i) a person married to you as a result of a valid civil or religious ceremony; or
 - ii) a person whose common law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose, provided the existence of such relationship includes continuous cohabitation and public representation of married status.

If you have been married to more than one person, you can only claim your current spouse or your current common law relationship if you have been cohabiting for more than 12 months.

Dependents attending school/university outside Canada

When traveling or attending school outside Canada, your group benefit plan provides coverage for emergency medical treatment for a period of 365 days from the date you leave your province of residence.

Before you leave

- Make sure you have arranged for continuation of your provincial health care coverage. Extended health coverage is invalid if Provincial Health Care (MSP) is discontinued.
- Keep a copy of the Emergency Travel Assistance card with you so you have easy access to the toll-free number (1-800-265-9977 or 800-9221-9221*)

Co-ordination of Benefits

Payment of Extended Health Care, Emergency Travel Assistance and Dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, Manulife Financial has a right to receive and release information on benefits and if necessary, collect any overpayments made by it. Benefit payments will be determined as follows:

Order of benefit payment will be determined as follows:

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expenses).

If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expenses.

If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

GENERAL PROVISIONS

Co-ordination of Benefits (Continued)

For Claims incurred by you or your Dependent Spouse:

The Plan covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

When parents are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
- The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

Submitting a Claim for Co-ordination of Benefits

As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

Submit all necessary claim forms and original receipts to the Primary Carrier.

Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Time Limitations

A claim for any loss must be submitted within 15 months following the date the loss is incurred. However, in the event of termination of insurance, a claim must be submitted within 90 days following the date of termination of your insurance or the date following termination of a coverage or the policy.

GENERAL PROVISIONS

Medical Information Bureau (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

Manulife Financial or its reinsurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All Information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction. Their address is: MIB, 330 University Ave., Suite 501, Toronto, Ontario, M5G 1R7. Tel: (416) 597-0590.

EXTENDED HEALTH CARE

In the event you incur any of the Eligible Expenses listed below, you will be paid a percentage of such expenses, as outlined below:

Deductible	-	\$25 Single per calendar year; or \$25 Family per calendar year
Benefit Percentage	-	80% of the first \$1,000 of paid expenses per person; 100% thereafter in any calendar year.
Lifetime Maximum	-	\$250,000
Termination Age	-	Coverage ends upon your retirement.

Eligible Expenses

Describes the benefits provided and any specific limitations. Such expenses must be reasonable and customary, medically necessary and/or prescribed by a physician.

Hospital

Charges, in excess of the hospital's public ward charge, for semi-private or private accommodation.

Vision Care

Lenses and frames for eyeglasses or contact lenses or laser eye surgery, up to a maximum benefit of \$400 during any 24 consecutive months.

Vision care charges for surgical procedures or for the treatment of Keratoconus, up to a maximum benefit of \$150 per lifetime.

Ambulance

Licensed ambulance service, including air ambulance, to and from the nearest hospital where adequate treatment is available. (Note: If an ambulance is required outside your province of residence, these charges will be paid for under the *Emergency Travel Assistance* plan).

EXTENDED HEALTH CARE

Professional Services:

Charges for treatment (in excess of amounts payable by any Provincial Health Plan when permitted by law) by a practitioner who is registered and legally practising within the scope of his/her license, subject to the following maximums:

Practitioner	Calendar Year Maximum	Maximum per Visit
Chiropractor	\$250	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Podiatrist	\$250	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Naturopath	\$250	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Speech Therapist	\$200	Reasonable and customary charges.
Clinical Psychologist or Clinical Counselor	\$500 combined	Reasonable and customary charges.
Physiotherapist or Massage Therapist**	\$500 combined	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Acupuncturist	\$100	Reasonable and customary charges.

Note:

- * After the first 12 visits, eligible expenses for the remainder of that year will be based on reasonable and customary charges.
- **A new physician's written referral for treatment by a Massage Therapist is required every 6 months.
- X-ray: One x-ray per person per calendar year allowed for a Chiropractor and a Podiatrist.

Private Duty Nursing

Services of a registered nurse provided in your home or in the hospital, if you are a registered bed patient in a public general hospital in the province of British Columbia, to a maximum of \$5,000 in any 3 calendar years. If the maximum has been reached but not reinstated, the benefit will be paid at \$50 per day.

Services provided will be based on the schedule of fees of the Registered Nurses' Association of British Columbia. Services must be rendered by a nurse who is currently registered with the Registered Nurses' Association of British Columbia.

Charges for the following services are not eligible:

- Service performed by a nursing practitioner who is related to or lives with the patient.
- Service performed while the patient is in a nursing home or similar institution.
- Service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

Accidental Dental

Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing.

Medical Equipment

Rental or, at the Insurer's option, purchase of a hospital bed, wheelchair, respiratory equipment, oxygen and oxygen equipment, and other durable medical equipment usually found in hospitals.

EXTENDED HEALTH CARE

Orthopedic Shoes and Foot Orthotics

Charges for custom fitted orthopedic shoes and foot orthotics, including repairs and modifications, which have been specially designed and molded for the patient and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- description of the physical findings from the clinical examination;
- a brief description of the gait abnormality associated with the diagnosis; and
- confirmation that the product has been custom-made.

In order to be eligible for reimbursement, orthopedic shoes and foot orthotics must be prescribed, on an annual basis, by providers with the following professional qualifications:

- Medical General Practitioner or Specialist (MD); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M); and

must be dispensed by one of the following provider types:

- Medical General Practitioner or Specialist (MD); or
- Orthotist Co(c) or CPO(c); or
- Pedorthist C Ped (C) or C Ped (MC); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M).

Charges for custom fitted orthopedic shoes, including repairs and modifications, and modifications to stock item footwear, are limited to a maximum of \$400 per calendar year for an adult and \$200 for a dependent child. Charges for foot orthotics (including arch supports) are limited to a maximum of \$300 per person in any calendar year.

Medical Aids and Prosthesis

- Artificial eyes and limbs, but excluding myoelectric limbs.
- Braces (excluding foot braces), trusses, collars, casts, crutches, and quad canes.
- Stump socks, up to a maximum of \$200 per calendar year.
- Ileostomy and ostomy supplies.
- Mastectomy brassieres, up to a maximum of \$150 per calendar year
- Wigs and hairpieces when required due to temporary hair loss as a result of a medical condition, up to \$500 per lifetime per person.
- Elastic support stockings, up to a maximum benefit of \$80 per person in any calendar year.

Hearing Aids

Cost and installation of hearing aids, excluding batteries, recharging devices and maintenance, subject to a maximum of \$400 in any 5 calendar year period. Replacements will only be covered when the hearing aid cannot be satisfactorily repaired.

EXTENDED HEALTH CARE

Exclusions

No Extended Health Care benefits are payable for any expense which is directly or indirectly related to:

- surgical procedures or treatment performed primarily for beautification
- self-inflicted injuries
- war, riot, insurrection or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any provincial government plan or workers' compensation
- periodic medical check-ups, third party examinations, physician's travel, broken appointments, communication costs, filing out forms, or physician's supplies
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy
- dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a physician acting within the scope of his licence
- charges for transport or travel, medical treatment or surgical procedure by a physician other than as specifically provided under this plan
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- experimental drugs or supplies and those not approved by Health and Welfare - Canada

Extension of Benefits

If you are disabled on the date insurance terminates, coverage for Extended Health Care will be continued for a period of 90 days from such date or during the continuation of such disability, whichever is less. Extended coverage ceases upon termination of the policy or Extended Health Care Insurance, if either occurs while coverage is being extended.

Survivor Benefits

Extended Health Care coverage for your dependents shall continue without premium payment until the end of the month following the month in which you die.

PRESCRIPTION DRUGS

(part of Extended Health Care)

Deductible	-	\$25 Single per calendar year; or \$25 Family per calendar year
Benefit Percentage	-	80% of the first \$1,000 of paid expenses; 100% thereafter in any calendar year

Eligible Expenses

Reasonable and customary charges for medically necessary drugs and medicines which are dispensed by a licensed pharmacist or physician and are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either

- a) drugs which by law require a prescription for purchase or
- b) drugs, medicines, injectable preparations and allergy serums, specified as covered expenses by Manulife Financial, including:
 - oral contraceptives
 - insulin preparations for diabetics
 - vitamin B12 for treatment of pernicious anemia
 - allergy serums when administered by a physician.

No benefit will be payable for:

- smoking cessation aids;
- fertility drugs; or
- drugs prescribed for the treatment of erectile dysfunction.

Supply Limits

Drug purchase is limited to a supply which is reasonably used within 90 days.

Purchase Options

Each time you have a drug claim, you have the option to:

- (A) Purchase your drugs and submit your receipts as a paper claim for reimbursement,

OR

- (B) Present your **ManuScript** Drug card to the pharmacist for point of sale assessment and no requirement to submit receipts to the Insurer. If a Brand Name drug is purchased with the **ManuScript Card** and there is a Generic substitute available, reimbursement will be based on the lowest cost Generic drug.

EMERGENCY TRAVEL ASSISTANCE

Your employer has arranged to provide you and your family with Emergency Travel Assistance coverage. *World Access Canada Inc.*, a multi-service corporation which assists travelers, has contracted with Manulife Financial to provide you with timely, efficient assistance when you travel.

Deductible	-	Nil
Benefit Percentage	-	100% of eligible expenses in addition to eligible services are covered.
Lifetime Maximum	-	Unlimited
Termination Age	-	Coverage ends upon your retirement.

How to Claim (ETA Plan # 9778)

Dial the number on the back of your identification card and you will be connected with the World Access Operation Centre. Be sure to carry your identification card (supplied by your employer) with you when you travel. The card contains the information you are required to give to World Access in the event you need assistance.

If your claim is for payment of \$200 or less, you will be asked to make the payment and keep the receipts. Your provincial health plan and the Insurer will reimburse you for the eligible expenses upon your return.

Services

The following services are covered in the event of an emergency which occurs while you or your dependents are traveling for non-medical reasons outside your province of residence:

- Multilingual assistance by toll-free telephone, 24 hours a day, 365 days a year, for insured individuals and providers of medical services to obtain aid and assistance;
- Referral to a legally qualified physician, dentist, legal advisor or an appropriate medical care facility;
- Assistance in arranging a cash advance from credit cards or family and friends to post bail and pay legal fees;
- Assistance in replacement (but not cost) of necessary travel documents or tickets in the event of theft or loss;
- Multilingual telephone interpretation services in the event of an emergency;
- A centre for communication of messages between you and your family, friends or business associates. Messages are held for 15 days;
- Medical consultation and monitoring of medical care and services if you or your dependents are hospitalized, and arrangement for contact with the patient, the attending physician and the patient's personal physician and family if necessary.

EMERGENCY TRAVEL ASSISTANCE

Eligible Expenses

Medical Services - Charges incurred for medical and surgical fees, hospital accommodations and prescribed drugs;

Emergency Transportation - Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in Canada. Upon written recommendation of a physician, such charges shall include a medical attendant if necessary who is neither a resident in the employee's home nor a relative of the employee or the employee's spouse;

Return of Deceased - Charges incurred for the return of a deceased employee or dependent to the place of former residence in Canada, subject to a maximum benefit of \$5,000 per individual;

* Return of Dependent Children - Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary;

* Return Trip Delay - Transportation - Charges incurred for delay of the return trip of an insured individual due to the hospitalization of that individual or another insured individual with whom the individual is traveling, limited to the cost of one way economy class transportation;

* Visit of Family Member - Charges incurred for transportation of an immediate family member to visit a hospitalized insured individual. Such individual must have been traveling alone and confined to a hospital for more than 7 days. The cost of transportation is limited to return economy fare for one family member. An immediate family member is defined as a spouse, parent, child, brother or sister or a person with whom the insured individual normally resides;

** Charges for these expenses are subject to a combined maximum benefit of \$5,000 per emergency.*

Return of Vehicle - Charges incurred in connection with the return of an insured's vehicle in the event the insured is unable to return it due to illness, injury or death, subject to a maximum benefit of \$500 per trip. The vehicle will be returned to the insured's residence or nearest appropriate rental agency. Such charges shall not include commercial transport vehicles;

Return Trip Delay - Accommodation - Charges incurred for commercial accommodation and meals for insured individuals while staying with a hospitalized insured family member when their return trip is delayed due to an illness or accident. Such charges are subject to a maximum benefit of \$700 per family;

Convalescent Benefit - Charges incurred for accommodation for insured individuals requiring convalescence following hospitalization, subject to a maximum benefit of \$75 per day for not more than 5 days for each insured individual.

EMERGENCY TRAVEL ASSISTANCE

Exclusions

The foregoing list of services shall not include any of the following:

- charges for surgical procedures or treatment performed primarily for beautification;
- charges for services or supplies resulting from self-inflicted injuries;
- charges for bodily injury resulting from war (whether declared or undeclared), riot, insurrection or civil commotion;
- charges for an illness or injury for which benefits are payable under any provincial government plan;
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- charges which are not medically necessary for the care and treatment of any existing or suspected injury, disease or pregnancy
- charges for dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a physician acting within the scope of his licence
- charges for transport or travel, other than as specifically provided under this plan;
- charges for medical treatment which is not usual or customary, or is experimental or investigational in nature;
- charges for experimental drugs or supplies and those not approved by Health and Welfare - Canada;
- charges which are not incurred as a result of an emergency while travelling;
- charges in connection with childbirth and medical complications resulting from childbirth when the delivery takes place after the beginning of the 32nd week of pregnancy.

Liability

The Insurer is not responsible for the availability, quantity, quality or results of any medical treatment received by an insured individual, or for the failure of an insured individual to receive Medical treatment for any reason.

Travel to Countries in Civil Distress

If you or your dependents plan on traveling to a country that may be under distress or in strife, you should be aware that there may be difficulty obtaining Emergency Travel Assistance while in that country.

The Department of Foreign Affairs and International Trade publishes and updates a list of countries that are currently affected. This list can be obtained from World Access Canada Inc. by calling one of the telephone numbers on the back of your Emergency Travel Assistance identification card.

If you have further concerns, please contact your Plan Administrator.

DENTAL EXPENSE BENEFIT

In the event you incur any of the eligible expenses listed below, you will be paid a percentage of such expenses as outlined below:

Deductible	-	Nil
Benefit Percentage	-	100% for Plan A - Basic Services 65% for Plan B - Major Restorative Services 60% for Plan C - Orthodontics
Benefit Maximums	-	Unlimited for Basic and Major Services \$2,160 per lifetime for Orthodontic Services
Termination Age	-	Coverage ends upon your retirement.

Dental Fee Guide

The fee guide established for the B.C. Colleges/University Colleges in effect on the date the charge is incurred. If referred to a specialist, the eligible expenses will be based on the lesser of the fee schedule amount plus 10%, or the specialist's guide (when a current one exists).

Submission of Treatment Plan

As a service to you, Manulife Financial will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your employer, including pretreatment x-rays if the proposed treatment involves crowns, dentures or bridgework.

Extension of Benefits

Procedures for endodontic treatment (root canal therapy), dentures or crowns and bridgework which commenced prior to the cancellation date of coverage, will be considered work in progress and will be reviewed for payment if the work is completed within 30 days of the date your coverage terminated.

Eligible Expenses

Plan A - Basic Services

Diagnosics: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- Standard oral examinations: two per calendar year.
- Specific oral examinations.
- Consultations: 2 units of time per calendar year.
- X-rays, limited to the dollar equivalent of a complete mouth series each calendar year, including:
 - i) diagnostic x-rays, and
 - ii) incomplete mouth series, included in the yearly maximum and limited to once in a three year period, and
 - iii) panoramic x-ray, included in the yearly maximum and limited to once in a five year period.
- Diagnostic models: one set per calendar year.

(One unit of time = 15 minutes)

DENTAL EXPENSE BENEFIT

Eligible Expenses (Continued)

Preventive Services: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- Fluoride treatment: twice per calendar year.
- One unit of polishing: twice per calendar year.
- Scaling and/or root planing: 16 units in any calendar year.
- Fixed space maintainers.

(One unit of time = 15 minutes)

Restorative Services: Necessary services to restore tooth surfaces broken down as a result of decay.

- Fillings (amalgam, silicates, resins and composites). Note that composite white fillings on molar teeth will be cut back to the cost of an amalgam restoration.
- Stainless steel crowns: once per tooth in a five year period.
- Gold onlays: once per tooth in a five year period, only when three surfaces (mesial, occlusal and distal) of the tooth are to be restored and one or more cusps are missing. When an onlay or series of onlays is planned, mounted x-rays and diagnostic models must be submitted for approval before treatment starts.
- Where other material would suffice, you will be responsible for the difference between the cost of gold and the cost of alternative material. Gold foil will be covered only when used to repair existing gold restorations.

Surgical Services:

- Extractions.
- Other routine oral surgical procedures (surgical removal of impacted teeth, residual roots and associated post-operative care).

Endodontics:

- Treatment of diseases of the pulp chamber and pulp canal (root canal): once per tooth per lifetime of patient.
- Root amputation.

Periodontics: Treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth, but not bone or tissue grafts.

- Acute infections, occlusal adjustment.
- Gingival curettage, gingivoplasty, gingivectomy or osseous surgery.
- Special periodontal appliances.

Prosthetic Repairs:

- Repair, rebasing and relining of dentures.
- Removal and recementation of fixed appliances.

DENTAL EXPENSE BENEFIT

Eligible Expenses (Continued)

Plan B - Major Restorative Services

Those services required for major reconstruction of teeth that have deteriorated and for replacement of teeth that are missing.

Prosthetic Appliances, Crown and Bridge Procedures: Benefit will be payable for the following eligible expenses:

- Crowns and/or bridges (porcelain crowns are covered on molar teeth);
- Onlays and/or inlays involved in bridgework;
- Partial dentures;
- Complete upper and lower dentures - these may be provided by a dentist or licensed Dental Mechanic.

No benefits will be paid for duplication of the above services within a 5 year period or for the replacement of dentures which are lost, broken or stolen.

Plan C - Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

Exclusions

No benefit is payable for the following:

- Miscellaneous charges such as for counselling, travel, broken appointments, completion of forms, written reports or communication costs.
- Services or supplies that are primarily for cosmetic dentistry.
- Services or supplies resulting from self-inflicted injuries.
- Services or supplies resulting from war (whether declared or undeclared), riot, insurrection or civil commotion.
- Services or supplies resulting from committing or attempting to commit an assault or criminal offence.
- Hospital charges for room and board and related services and supplies.
- Services which are payable by any provincial government plan.
- Services or supplies for which no charge would normally be made in the absence of group benefit coverage.
- Any dental examination required by a third party.
- Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease.
- Services and supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
- Services or supplies in connection with any procedures not listed as an eligible expense.

Survivor Benefit

Dental Expense benefits for your dependents shall continue without premium payment until the end of the month following the month in which you die.