

**The OHA Dental Plan for
ONA Early Retirees**

Policy No. 542 300

BENEFIT SUMMARY

ONA – Dental Plan for Early Retirees (Ages 60 to 64)

Dental Care Benefit

Deductible	None
Percentage or Reimbursement	100% for Preventive Services 100% for Basic Services including Endodontics and Periodontics 50% for Major Services 50% for Orthodontics
Maximum Benefit	Unlimited for Preventive and Basic Services including Endodontics and Periodontics \$1,000 for complete and partial dentures per insured person each calendar year \$1,500 for crowns, bridgework (and repairs to same) per insured person each calendar year
Orthodontics Maximum Benefit	Lifetime maximum of \$2,000 per insured person
Fee Guide Year	Current Fee Guide
Termination	Whichever occurs first, <ul style="list-style-type: none">• the end of the month when the retired member turns age 65;• the retired member's death;• the date required annual premium is no longer paid.

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

ELIGIBILITY

Full time nurses who are members of ONA, age 60 and over but under 65, who have reached age 60 at retirement, who retire on or after April 1, 2008 from a Participating Hospital and who apply for coverage within 30 days from their retirement date are eligible to this ONA Dental Plan for Early Retirees.

Eligible dependents include the retired nurse's legal or common-law spouse who has been living with the member for at least one year and children under age 21 or under age 25 if they are attending school on a full time basis.

EFFECTIVE DATE OF COVERAGE

Coverage will become effective on the date the member retires.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to the Insurer that an insured person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a dentist, the Insurer will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable policy provisions.

To be eligible, the expenses must have been performed

- 1) by a dentist; or
- 2) by a dental hygienist under the supervision of a dentist; or
- 3) by a licensed denturist when such services are within the scope of his licence.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

PREVENTIVE SERVICES

EXAMINATIONS

- Complete oral examination, once every 3 years
- Recall oral examination, once every 9 months for adults, once every 6 months for children
- Specific oral examination, once every 6 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

- Complete series of periapical films or panoramic radiographs, limited to one series once every 3 years
- Intra oral films, including bitewing films (once every 9 months for adults, once every 6 months for children), and radiographs to diagnose a symptom or examine progress of a particular course of treatment
- Interpretation of radiographs from another source
- Photography
- Radiograph of the hand and wrist as a diagnostic aid for dental treatment
- Temporomandibular joint films
- Tomography

LAB TESTS AND EXAMINATIONS

- Bacteriologic cultures/smears to determine pathological agents
- Biopsies
- Pulp vitality tests
- Unmounted diagnostic casts

CASE PRESENTATION AND EXPLANATION

- Consultation with a patient (a day other than the examination date), limited to 2 in a 12 month period

PREVENTIVE SERVICES

- Polishing, once every 9 months for adults, once every 6 months for children
- Light scaling for preventive purposes rather than therapeutic, once every 9 months for adults, once every 6 months for children
- Topical application of fluoride, once every 9 months
- Finishing restorations
- Pit and fissure sealants, for Children under Age 16
- Interproximal discing
- Space maintainers for missing primary teeth, for Children under Age 16
- Prophylactic odontotomy/enameloplasty
- Oral hygiene instructions, once every 9 months

BASIC SERVICES, ENDODONTICS AND PERIODONTICS

RESTORATIONS

- Amalgam (silver)
- Composite restorations
- Retentive pins for amalgam and composite restorations
- Preformed stainless steel and polycarbonate crowns
- Caries / trauma / pain control, separate procedure from restoration
- Occlusal equilibration, 8 units per calendar year

ENDODONTICS

- Treatment of disease of the pulp chamber and pulp canals (root canal therapy)
- Bleaching (endodontically treated tooth/teeth)

PERIODONTICS

- Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited:
 - a) post-operative visits, 4 visits per calendar year
 - b) curettage performed by a dentist, once per period of 60 months
 - c) scaling for therapeutic purposes limited to a maximum of 12 units per calendar year
 - d) adjustments to periodontal appliance to control bruxism only, limited to one adjustment per calendar year

MAINTENANCE OF REMOVABLE DENTURES

- Repair
- Structure addition
- Relining
- Rebasing
- Resetting
- Adjustments to dentures, 3 months after insertion
- Denture adjustments including minor adjustments, once every 6 months.

ORAL SURGERY

- Extractions - uncomplicated and complex
- Removal of residual roots
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty
- Alveolar ridge reconstruction
- Extension of mucous folds
- Excisions
- Incisions
- Frenectomy
- Fractures
- Repairs, lacerations
- Reduction of bone, tuberosity
- Management of temporomandibular joint dislocation
- Miscellaneous surgical procedures

OTHER SERVICES

- Only general anaesthesia and conscious sedation are covered. These expenses are eligible if they are administered in conjunction with extractions.
- Professional visit

MAJOR RESTORATIVE SERVICES

PROSTHODONTICS

Expenses incurred for a permanent initial prosthodontic appliance, such as partial or full removable denture or fixed bridge, are covered if such appliance was necessary because of the extraction of at least one natural tooth while the insured is covered under this Benefit or a comparable benefit held by the policyholder in force immediately before the effective date of this Benefit.

Replacement of an existing denture or bridge by a permanent denture or bridge:

- 1) if the replacement was necessary because of the extraction of one or more natural teeth while the insured is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, or
- 2) if the existing denture or bridge is at least 5 years old; or
- 3) if the existing denture or bridge is temporary and is being replaced with a permanent denture or bridge within 12 months of the installation of the temporary appliance. With respect to a permanent appliance that replaces a temporary one, the amount eligible for reimbursement will be reduced by the amount previously reimbursed by the Insurer for the temporary appliance.
- 4) a temporary appliance which is at least 12 months old will be considered to be a permanent denture or bridge for the purposes of this provision.

REMOVABLE DENTURES

- Complete denture
- Immediate complete denture
- Complete or partial overdenture
- Transitional denture
- Partial denture including cast in chrome (but not in gold)
- Partial denture remake
- Remount with occlusal equilibration
- Therapeutic tissue conditioning

FIXED PROSTHODONTICS (bridges)

- Abutment preparation under existing partial denture clasp, once every 5 years
- Abutments and pontics
- Repairs
- Bridge removal
- Recementation
- Diagnostic cast
- Splinting, once every 5 years

OTHER SINGLE RESTORATIONS

- Onlays, veneers applications, inlays, crowns
 - a) for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite
 - b) temporary crowns are considered to be part of the final restoration
 - c) replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old
 - d) only metal crowns on molars are reimbursed
- Porcelain repair
- Retentive pins, pivots, cast posts
- Gold foil restorations, once every 5 years
- Recementation
- Removal of an inlay or crown

ORTHODONTICS

If an insured person, while insured under this Benefit, incurs Eligible Expenses that are for necessary dental treatment, which has as its objective the correction of malocclusion of the teeth, as listed below, the Insurer will reimburse such expenses, in accordance with the applicable percentage and maximum.

- services for diagnostic purposes
- preventive orthodontic treatment
- comprehensive orthodontic treatment
- appliances to control harmful oral habits
- orthodontic cast
- space maintainers
- repairs (under observation and adjustment)
- myofunctional therapy
- appliances adjustment, repair and maintenance

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide. When there are two or more courses of treatment available to adequately correct a dental condition, this plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 50% of the suggested fee in the appropriate Fee Guide, for the particular dental treatment requiring the lab services.

No reimbursement will be made under this Benefit for the following:

- 1) any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;
- 2) charges for nutritional counselling and dental plaque control programs;
- 3) any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction or for the restoration of occlusion;
- 4) charges levied by a dentist for broken appointments, completion of claim forms or advice by telephone;
- 5) expenses incurred for bacteriologic cultures/smears followed by a Chlorzoin treatment;
- 6) expenses incurred for implants;
- 7) expenses incurred for duplicate diagnostic casts (unmounted);
- 8) expenses incurred for anaesthesia administered by acupuncture;
- 9) any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;
- 10) dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;
- 11) services, treatment or supplies provided to the Member by the Employer;
- 12) any dental treatment rendered outside Canada;
- 13) dental services and supplies not included in the list of Eligible Expenses;

- 14) Eligible Expenses that result directly or indirectly from the following:
- a) intentionally self-inflicted injuries while sane or insane;
 - b) committing, or attempting to commit a criminal offence;
 - c) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
 - d) civil commotion.

EXCLUSIONS RELATED TO PROSTHESES AND CROWNS

No reimbursement will be made under this Benefit for the following:

- 1) expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen;
- 2) prosthetics with precision attachments or stress breakers;
- 3) precision attachments and telescoping crown units for fixed bridgework;
- 4) preformed polycarbonate crowns, except in the case of primary teeth;
- 5) transfer coping for crowns.

EXCLUSIONS RELATED TO ORTHODONTIC TREATMENT

No reimbursement will be made under this Benefit for the following:

- 1) replacement or repair of an orthodontic appliance;
- 2) patient motivation (psychological evaluation and progress, per visit);
- 3) procedure requiring the insertion of an adjustable orthodontic appliance before the person is insured under this Benefit.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for an insured person is expected to exceed \$500, the member should submit a detailed treatment plan to the Insurer before treatment commences. The Insurer will then advise the member of the amount of reimbursement for which the insured person is eligible in accordance with the provisions of this policy. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the dentist who first proposed the treatment, otherwise the member will be required to submit a new treatment plan to the Insurer for re-assessment.

CO-ORDINATION OF BENEFITS

If an individual, who is insured for a Benefit that is subject to the co-ordination of benefits provision, is also insured under any other Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated and the amount payable under the policy will be prorated so that the benefits payable under all Plans will not exceed 100% of the incurred expenses.

BENEFIT TERMINATION

No benefits are payable for expenses incurred after the date the insurance of the member terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by the Insurer prior to such termination date.

PROOF OF CLAIM

If the dentist uses the Electronic Data Interchange (EDI), the member is not required to submit a claim to the Insurer. EDI allows the dentist to validate the eligibility, to confirm that the care provided or prescribed is covered, and to obtain confirmation of the amount payable directly to the Member, or the dentist, by the Insurer, and the amount payable by the insured person. The dentist himself submits the benefit claim via EDI and gives a copy of the confirmation to the insured person.

If the dentist does not use the Electronic Data Interchange (EDI), the insured person must submit a benefit claim to the Insurer. All claims must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred.

The Insurer reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

PAYMENT OF ORTHODONTIC CLAIMS

Notwithstanding anything to the contrary under the CLAIMS provision of this policy, the payment of orthodontic claims will be made on one of the following bases:

- 1) if a single charge is estimated for the entire course of treatment and the insured person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, the Insurer will reimburse the member each time he submits a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or
- 2) if in lieu of a single charge, a charge is made for each treatment as it is performed, the insurer will reimburse the member as each charge is incurred.