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 the overall lifetime maximum is $2,500 per person.

Schedule of Orthodontic Benefits Procedures

Procedures	â
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 maximum reimbursement of $1,200
Subsequent treatment	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 as well as the payment schedule 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 expense 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 service 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.
- Facings on crowns or on pontics (false teeth) in back of the second bicuspid.
- Periodontal splinting and ligation.
- Implants and/or implant surgery (alternative benefit provisions may apply).
- Treatment other than by a licensed physician, dentist, dental auxillary, denture therapist or hygienist.
- Charges for writing prescriptions, duplicating records, or preparing reports.
- Appliances to increase vertical occlusal dimension.
- Mouthguards except as listed under Major Dental Services.
- Crowns and restorations except those listed under Major Dental Services.
- House calls.
- Training and supplies used for personal oral hygiene or dietary nutritional counseling.
- Professional consultations (profession to profession).
- Plaque control programs.
- 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 a 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 has not paid for it during the past five (5) years.

United Food and Commercial Workers
Trusteed Dental Plan – Ontario

Revised August 2019

Your Dental Care Benefit 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/Benefits 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)

Or fax:

416-674-1525

Or Email:

theontariodentalplan@pbas.ca

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

Plan Website:

theontariodentalplan.ca

Claims Portal

A new claims submission Portal has been launched for use by Eligible Plan Members.

Please visit: https://mypbas.pbas.ca/user/theontariodentalplan and register on the Portal. You will require a Certificate Number which you can obtain by contacting your Administrator.

You will then be able to access exciting new features such as claim submission, claim history, benefit balance, and much more. You can also sign up for direct deposit and have your claim payment deposited directly to your bank account.

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.

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

Since benefit Coverage changes periodically, a Six Page Plan Guide has also been prepared as a supplemental document which outlines the coverage that may change from time to time.

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.

It is important that Plan Members and their families read this booklet before beginning dental treatment.

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.

Table of Contents

Introduction

Details Of Coverage

Claims Submission & Related Matters

Tax Considerations

Operation of the Plan

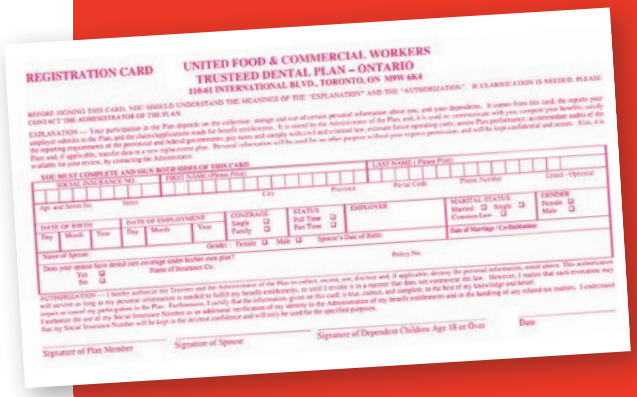
The Plan is financed from a Trust Fund into which employer Contributions are made. The amounts and timings of those Contributions are specified in Collective Agreements between the Union and Participating Employers. In turn, the records of Contributions are the basis upon which Employees become Plan 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, Local 175 and by representative employers – four (4) 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 benefits) 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, all Plan Members are asked to complete a Registration Card for submission to the Administrator.


REGISTRATION CARD

UNITED FOOD & COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN – ONTARIO
110-61 INTERNATIONAL BLVD., TORONTO, ON M9W 6K4

BEFORE SIGNING THIS CARD, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION". IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.

EXPLANATION — Your participation in the Plan depends on the collection, storage and use of certain personal information about you, and your dependents. It comes from this card, the reports your employer submits to the Plan, and the claim/application made for benefit entitlements. It is stored by the Administrator of the Plan, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the Administrator.

YOU MUST COMPLETE AND SIGN BOTH SIDES OF THIS CARD

SOCIAL INSURANCE NO. | FIRST NAME (Please Print) | LAST NAME (Please Print)

Apt. and Street No. | City | Province | Postal Code | Phone Number | Email - Optional

DATE OF BIRTH | DATE OF EMPLOYMENT | COVERAGE | STATUS | EMPLOYER | MARITAL STATUS | GENDER

Name of Spouse | Spouse's Date of Birth | Policy No. | Date of Marriage / Co-Habitation

Does your spouse have dental care coverage under his/her own plan? | Name of Insurance Co.

AUTHORIZATION — I hereby authorize the Trustees and the Administrator of the Plan to collect, record, use, disclose and, if applicable, destroy the personal information, stated above. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given on this card, is true, correct, and complete, to the best of my knowledge and belief.

I authorize the use of my Social Insurance Number as an additional verification of my identity to the Administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Signature of Plan Member | Signature of Spouse | Signature of Dependent Children Age 18 or Over | Date

Plan Members are asked to complete a Registration Card.

It includes the Plan Member's name, date of birth, social insurance number, contact information, e-mail address, telephone number, Dependant identifications, and authorization to use the data in prescribed ways, (Co-ordination of Benefits, etc.) more. You can also sign up for direct deposit and have your claim payment deposited directly to your bank account.

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 or by using the Portal.

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 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 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 Trust Fund.

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

Co-ordination of Benefits (COB) means when a claimant is eligible for dental care benefits from more than one plan. The total, combined reimbursement may not exceed one hundred (100%) percent of the actual charges incurred. Make sure the Administrator is advised of other coverage that is available to you.

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 cohabitated with the Plan Member, in a common-law or other marriage-like relationship for at least one (1) year. If the Plan Member has more than one (1) Spouse, only the person named as such on the Registration Card, or as updated by using the Portal will be covered.

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.

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.

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 or The 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.)

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.

Requirement 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 their 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 is accepted by the Administrator

Details of Coverage

1.1 Who is eligible for Coverage?

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

1.2 When does Coverage begin?

Coverage begins on the first day of the calendar month following the date that the Plan Member satisfies the Requirements For Eligibiltiy. 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 (1st) day of January following a twelve- (12-) 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 one thousand, one hundred (1,100) hours of employment.

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

1.3 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 one thousand, one hundred (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 (1st) 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.

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

The Administrator will notify the Employee in writing, annually.

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

1.5 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 Plan Member's and the Dependants' Coverage.

If Coverage – either the Plan Member's or the 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. Further, Contributions are required during such leave.

1.6 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 (1) continuous period of disability which prevents the Plan Member from working.

Such Coverage is intended to run from the first (1st) 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 (1) continuous period of disability (as referenced above) means: an uninterrupted absence from work; or, two (2) 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 (1) 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.

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

Coverage may be continued for up to thirty-six (36) months, during periods of an 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 an approved leave of absence, and must be continued without interruption for the desired period of Coverage.

Coverage is continued for up to three (3) continuous months during any period of a temporary lay-off for Plan Members and Dependants who had Coverage immediately prior to the commencement date of such lay-off. After three (3) months, the Plan Member may continue Coverage for up to thirty-three (33) additional months by making Self-payments. Such Self-payments must be made for the period beginning at the first (1st) day of the calendar month immediately following the above-noted continuous Coverage for three (3) months and must be continued without interruption for the desired period of Coverage.

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

1.8 Can Coverage be continued after retirement?

Plan Members who retired before age 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 sixth-fifth (65th) birthday, Coverage will terminate at the end of the calendar month for which the last of such payments was made.

Note: Retirement means that a person is in receipt of a pension and not engaged in any occupation or employment for remuneration other than with a Participating Employer. If the Plan Member wishes to extend Coverage beyond the date of retirement, the Participating Employer must confirm that the Employee is retiring as at a specific date by completing an Absent Form Work Form and sending same to the Administrator.

1.9 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 Dependants continue to satisfy all of the other Plan rules.

1.10 How are Self-payments to be made?

Self-payments (as defined in items 1.6, 1.7 and 1.8) 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 (1st) payment must reach the Administrator, on or before the later of 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.

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 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 end 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 if before age sixty-five (65);

iii. at the end of the calendar month in which the Plan Member retires, is not scheduled to work, or commences an approved leave of absence other than for maternity or parental leave, has been on disability leave for three hundred and sixty-five (365) days or at the end of a three (3) month temporary lay-off – 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 requirements for Dependants' Coverage (see item 1.2); or,

iv. at the end of six (6) months following the month in which the Plan Member dies.

Note: Item 2.9 explains the circumstances in which benefits may be paid at 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 time 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 (1st) 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 persons 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 Submission & Related Matters

2.1 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 claim payments.

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

Note: Claim forms may be downloaded from the website or Portal or secured from the Administrator, as well as a Dentist.

2.2 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, at age nineteen (19) or older, it must be established that the child is incapable of self-sustaining employment because of a mental or physical disability, or is enrolled in full-time attendance at School; or,

ii. when a course of dental services (including dentures and other appliances) is expected to cost more than Three Hundred ($300) Dollars, 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.

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.

2.3 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.

2.4 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.

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

Yes.

2.6 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 one hundred (100%) percent 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.

2.7 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 Spouse'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.) The Plan Member must provide an Explanation of Benefits (EOB) from the first payer.

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 co-ordinated, with the second payer. The Plan Member must provide and exchange the required documentation.

2.8 Can The Plan help, in any way, if a claim payment from a provincial workers compensation agency [i.e. the Workplace Safety and Insurance Board ("WSIB"), 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 WSIB, The Plan may offer a temporary payment, provided all of the following conditions are fulfilled.

- The WSIB forms were fully completed when they were first submitted.
- Some, or all of the dental services, upon which the WSIB payment is based, are identical to those normally covered by The Plan.
- Complete copies of claim forms, sent to WSIB, 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 WSIB 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 WSIB and the amount that The Plan would normally reimburse for the specified service and/or supplies.

2.9 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 ninety (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 by The Plan 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.

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 Benefit payments 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 to five (3-5) business days from the date on which a complete, accurate claim form is received by the Administrator by regular mail or the Portal. If the member has registered for direct deposit, members can expect to see reimbursement in their bank account in 4 additional business days. For cheque reimbursement, return postal time, must, of course, be added to that three to five (3-5) 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. Registration for direct deposit can be made through the Portal.

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 Sub-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 that 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.

2.15 Where should claims be submitted?

Claims can be submitted as follows:

By mail:

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

By Fax:

416 674 1525

By Portal:

https://mypbas.pbas.ca/user/theontariodentalplan

By E-Mail:

theontariodentalplan@pbas.ca

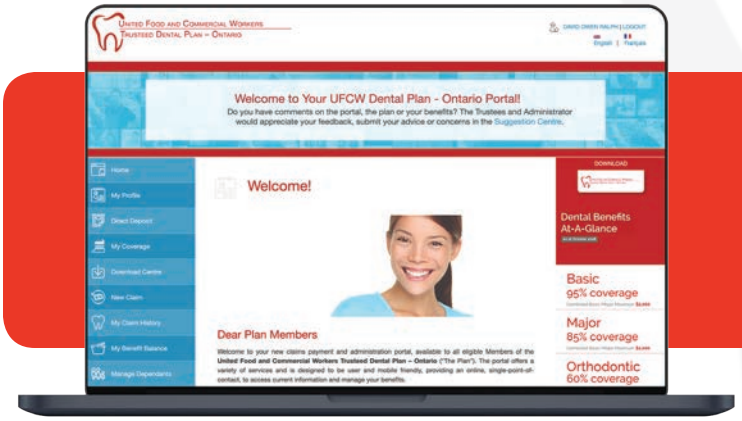
Tax Considerations

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

No.

3.2 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 expense deduction from taxable income.



Please visit The Plan website for additional information at: theontariodentalplan.ca

Notes: