APPENDIX A: DENTAL BENEFITS

Full-time Employees

1. You will be reimbursed:

a) 100% of eligible expenses for Basic, Major and Orthodontic dental services.

2. Basic and Major Dental benefits are subject to a combined maximum per person per calendar year as negotiated by your Union/Association.

3. Orthodontic services (braces) are subject to a lifetime maximum per person (exclusive of the Basic /Major dental maximum) as negotiated by your Union/Association.

4. Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association which is in effect at the time the services are provided.

Part-time Employees

5. Your benefit maximum will be 50% or 75% of the full-time maximum as negotiated by your Union/Association.

6. You will be reimbursed:

b) 100% of eligible expenses for Basic, Major and Orthodontic dental services.

7. Basic and Major Dental benefits are subject to a combined maximum per person per calendar year as negotiated by your Union/Association.

8. Orthodontic services (braces) are subject to a lifetime maximum per person (exclusive of the Basic /Major dental maximum) as negotiated by your Union/Association.

9. Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association which is in effect at the time the services are provided.

Basic Services Covered (Plan B)

10. Diagnostic:

a) Complete examination, once every 3 calendar years.

b) Recall or oral examinations covered twice in each calendar year, but not more than once in a 5-month period

c) Periapical x-rays.

d) Full mouth x-rays or panorex x-rays once every 2 calendar years if necessary.

11. Preventive:

a) Combination of 1 1/2 units of polishing and/or scaling (the removal of deposits and stains from the tooth surface) twice in each calendar year, but not more than once in a 5-month period.

b) Topical application of fluoride. Up to 2 applications in each calendar year, but not more than once in a 5-month period.

c) Space maintainers (except when used for orthodontic purposes).

12. Extractions:

a) Uncomplicated procedures for the removal of teeth which are beyond restoration.

13. Oral surgery:

a) Complicated surgical procedures performed in the dentist's office including post-operative care.

14. Restorative:

a) Fillings made of amalgams, silicates, plastics and synthetic porcelains.

b) Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.

15. Endodontics:

a) The usual procedures required for pulpal therapy and root canal filling.

16. Periodontics:

a) The usual procedures for treatment of the diseases of the tissues and bones supporting the teeth.

17. Anesthesia:

a) General anesthesia or nitrous oxide analgesia administered in the dentist's office.

18. Consultations:

a) Consultations required by the attending dentist.

19. Drugs:

a) Cost of medications and injections given in the dentist's office.

Major Services Covered (Plan C)

20. Extensive restorations:

a) Inlays and onlays (One per tooth every 5 calendar years).

b) Jackets, crowns and bridges to rebuild and replace missing teeth. (Only one procedure per tooth every 5 calendar years.)

Note: Please refer to point number 6 of "Exclusions and Limitations".

21. Prosthetic:

a) Partial or complete upper and lower dentures provided by a dentist or licensed denturist. Each procedure limited to once every 5 calendar years. Allowances include all adjustments.

Orthodontic Services Covered (Plan D)

22. Orthodontic services normally specify an initial fee, and monthly or quarterly fees for on- going treatment. You will receive reimbursement towards the initial fee, and on-going services as they are received. You will not be reimbursed in advance for orthodontic services not yet received.

23. The plan also recognizes specialists, dental mechanics and denturists where permitted by law to deal with the public in which case the basis for payment of covered services will be the applicable Manitoba Dental Fee Guide agreed to as a result of collective bargaining.

Please Note: Coverage and eligibility may differ from bargaining group to bargaining group. If you are uncertain of your eligibility and/or coverage limits, contact your Blue Cross Departmental Administrator(s) before undertaking treatment.

Pre-Treatment Authorization

24. The pre-authorization requirement has been established primarily to protect you, by having possible misunderstandings resolved before expensive dental work is carried out. If the cost of all treatments planned is expected to exceed $600.00, Manitoba Blue Cross must approve the work in advance. After listing the work planned, your dentist will submit your claim form, with supporting x-rays, directly to Manitoba Blue Cross. A notice of assessment will be issued to you and your dentist.

Importance of the Fee Guide

25. Benefits paid by the plan are based on a specific dental fee guide established by your provincial dental association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide. When going to a dentist for the first time, it is suggested that you inquire about how they set the rates before any work is carried out. If the dentist charges more than the fee guide, you will be responsible for the excess. In no event will the plan pay more than the dentist's actual charge.

Exclusions and Limitations

26. Manitoba Blue Cross will not pay for the following:

a) Services purely cosmetic in nature, or for cosmetic reasons.

b) Congenital malformations i.e. cleft palate prosthesis.

c) Fees arising out of extra services arranged for privately between the patient and dentist.

d) Oral hygiene instruction and plaque control programs.

e) Charges for appliances, which have been lost, broken or stolen.

f) Gold, crown, fixed bridge, veneers or other extensive treatment when another material or procedure would have been a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute was possible, the covered expense would be that of the customary substitute.

g) Separate charges for general anesthesia except in connection with office procedures as specified in your plan.

h) Bleaching of teeth.

i) Root canal on a permanent tooth more than once per lifetime per tooth.

j) Snoring or sleep apnea appliances.

k) Charges for treatment other than by a dentist, except for treatment performed in a dental office under the supervision and direction of a dentist by personnel duly licensed or certified to perform such treatment under applicable professional statutes and regulations.

l) Diagnostic photographs.

m) Precision attachments.

n) Hypnosis and dental psychotherapy.

o) Provision for facilities in connection with general anesthesia.

p) Polishing restorations.

q) Any procedure in connection with forensic dental.