

The Canadian Forces Dental Care Plan

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Introduction

This booklet describes the benefits available under the Canadian Forces Dental Care Plan (DCP). The cost of the DCP is fully paid by the Treasury Board.

The complete terms and conditions of the Plan are set out in the DCP Rules. Since this booklet has been written for information only, if any conflict exists between it and the DCP Rules, the Rules will take precedence.

The booklet is divided into three parts: the first part deals with membership in the Plan, the second part describes the benefits, the levels of reimbursement and the limitations on benefits, while the third part explains how to submit a claim.

This booklet is intended to give you general information about the Plan. For more specific information, contact your Unit Orderly Room.

PART I - Membership

1. Who is covered by the Plan

(for the purpose of this booklet, the term "plan" refers to the Dental Care Plan for Public Service employees and their eligible dependants, eligible dependants of members of the Regular Force, members of the Reserves or their eligible dependants as applicable and the eligible dependants of the RCMP members)

The Plan covers all eligible spouses and children.

(a) Eligible spouse

For the purposes of this Plan, "spouse" means a person legally married to you or a person who is living with you in a common-law relationship which has been recognized in accordance with the provisions of CFAO 19-41.

(b) Eligible children

For the purposes of this Plan, "child" means your unmarried child or children (including an adopted child, a step-child or a foster-child), provided he or she is not a member of the Plan as an employee:

under twenty-one (21) years of age;

between twenty-one (21) and twenty-five (25) years of age and in full-time attendance at an educational institution; or twenty-one (21) years of age and over with a mental or physical impairment who is incapable of engaging in self-sustaining employment and is primarily dependent upon you for support (**see note below**),

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2. When coverage starts

For a member who became eligible on or after 1 January, 1992, participation in the Plan commences following a waiting period of exactly three (3) months of continuous Regular Force or Primary Reserve service.

New dependants enjoy dental coverage from the date they become eligible dependants.

Note: This description must apply to your child on the date you become subject to the Plan, otherwise the child has to have been covered under the Plan immediately before his or her 21st birthday. If the child becomes impaired after reaching the age of 21, the child must have been covered as a student at the time the impairment began.

3. Termination of coverage

Your membership in the Plan ends automatically on the date of your release from the Canadian Forces.

Your spouse is no longer covered by the Plan when he or she ceases to be your spouse or when you are no longer an active member of the Canadian Forces.

Your child is no longer covered by the Plan when he or she ceases to be an eligible child (for example, a child reaches 21 years of age, or age 25 if in full-time attendance at school or university) or when you are no longer an active member of the Canadian Forces.

Exceptions:

If a given dental treatment requiring more than one sitting began while the employee and/or dependants were in the plan, coverage for that treatment will continue only if it is completed within 31 calendar days of the termination date. Examples include root canal treatment where the pulp chamber is opened prior to termination, a crown where the tooth is prepared and impressions are taken prior to termination of coverage, or ongoing active orthodontic treatment where the initial appliance was inserted prior to termination.

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4. Service Number (Applies to members of the Regular Force or Class C Service)

Upon becoming a participant in the Plan, you will use your Service Number (SN) as the certificate number for your dependants. You must be sure to record your SN on any claims which you submit on behalf of your eligible dependants and on all correspondence with the Plan Administrator. The SN identifies you to the Plan Administrator, The Great-West Life Assurance Company.

5. Leave without pay (Applies to members of the Regular Force or Class C Service)

If you go on authorized leave without pay for reasons of illness, maternity, paternity, adoption, education or for personal needs (for three months or less), employer-paid coverage will be extended to you for the total period of absence. If you proceed on any other type of leave without pay, you can maintain your coverage for a fee. For continued coverage in these circumstances, the full premium cost must be paid in advance on a quarterly basis. A table of monthly contributions is included in this booklet as [Annex A](#). Contact your Unit Orderly Room for further details.

If you fail to remit the required contributions within the applicable time, your membership will be suspended until the first of the month following the month you resume duty with pay.

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6. Coverage for Members of the Reserve Force

As a part of the Reserve Health Benefit Plan, some Reserve Force members and their dependants are eligible to participate in the Reserve Dental Care Plan. The rules of eligibility are:

- A member who is enrolled in the Primary Reserve, who is not covered by any other dental plan or programme and is in good standing with the Unit, may request and be assigned a reserve dental plan certificate number and will be covered by the plan. For new enrolments, the member will be eligible to participate in the plan on the day following three months of service.
- A member serving on Class A or Class B service (180 days or less) is entitled to dental care coverage for him/herself only, under this plan.
- A member serving on Class B service (in excess of 180 days) is entitled to comprehensive dental care through CF dental units. The member's eligible dependants, however, become eligible to claim for reimbursement of eligible dental services under this plan, for the duration of the member's Class B service.

PART II – Benefits

The Dependants Dental Care Plan provides coverage for specific services and supplies that are not covered under a provincial health or dental care plan. Further, the Plan covers only **reasonable and customary** dental treatment, necessary to prevent or correct dental disease or defect, provided the treatment is **consistent with generally accepted dental practices**.

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1. Eligible services

A detailed description of eligible services is provided in [Annex B](#). Below is a summary of the major features of the Plan's eligible services, by category.

(a) Benefits Reimbursed at 90%

Diagnostic:

(excluding services related to major prosthodontic)
examinations, x-rays, laboratory examinations

Preventive:

dental cleaning and polishing, Top of Pageical application of fluoride, space maintainers

Minor Restorative:

amalgam, silicate, acrylic or composite

Endodontics:

root canal therapy

Periodontics:

treatment of gums

Minor Prosthodontic: (services for removable dentures):

repairs and adjustments, relining and rebasing

Surgery:

extractions of teeth, other surgical procedures

Adjunctive Services:

emergency services not otherwise specified, anaesthesia

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(b) Benefits Reimbursed at 50%**Major Restorative:**

gold and porcelain restorations (inlays), crowns

Major Prosthodontic:

complete dentures, partial dentures, fixed bridges (abutments, pontics), repairs of fixed dentures (bridges)

Orthodontic:

(applies to a covered spouse or a covered child under 21 years of age or under 25, if in full-time attendance at school or university).

Surgical services, observation and adjustments, fixed appliances, removable appliances

Members should note that there are specific limits on how often certain services will be reimbursed. Please check [Annex B](#) to see where these limits apply.

In addition to reviewing the details of eligible expenses in [Annex B](#), it is important to note the exclusions and limitations set out in [Annex C](#).

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2. Maximum reimbursement for dental services

Except for orthodontic services, there is a reimbursement limit of \$1,250 per calendar year per covered person for all eligible dental services. If you, your eligible spouse or common-law partner and/or children join the DCP on or after July 1 of any given year, the maximum reimbursement amount per person, excluding orthodontic services, is \$625 for that year.

From January 1, 2004 to December 31, 2005, the reimbursement limit will be \$1,500 per calendar year per covered person, and \$750 if you or your eligible dependants join the DCP on or after July 1 of any given year.

Orthodontic services are subject to a separate lifetime limit of \$2,500 for each covered person for all eligible orthodontic services.

3. Limitations on reimbursement**(a) Deductible Amount**

For each calendar year, there is a minimum deductible amount on all dental expenses. Only the eligible expenses you incur during the year that exceed that deductible amount are eligible for reimbursement under the Plan.

The annual deductible amount is \$25 per covered person. However, where eligible expenses are incurred for more than one person in a family in a calendar year, the deductible amount will be limited to \$50.

Carry-over deductible: If the first dental expense in a calendar year is incurred in the last quarter of the year (October - December) and the applicable deductibles have been satisfied, a new deductible will not be applied in the following year.

(b) Co-insurance

Co-insurance means that you and the Plan share the cost of the services on a percentage basis. The Plan will reimburse you for a percentage of the cost of the covered expenses you have incurred. This percentage is applied to the amount of expenses that is in excess of the annual deductible amount. For example, **the Plan will reimburse you 50% of the costs for major restorative, major prosthodontic and orthodontic services (excluding diagnostic services in relation to orthodontia) and 90% for all other eligible services. You must pay the remainder.**

The appropriate percentage applied to the amount of expenses is currently based on the 1999 dental fee guide in effect in the province or territory in which the service is rendered.

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4. Covered charges

(a) Members serving in Canada

When you incur expenses for a particular eligible service or item, the plan recognizes only those amounts up to the tariff shown for the applicable service or item in the dental fee guide in effect in the province or territory in which the service is rendered. Dental expenses incurred on or after January 1, 2000 will be reimbursed based on the provincial or territorial dental fee schedule, and Specialist fee schedule where available, in effect the previous year. For dental treatment rendered in the province of Alberta on or after January 1, 2000, reimbursement of dental expenses will be based on a table of fees which is the 1997 Alberta fee schedule increased by an inflationary factor. You will have to bear any portion of an expense in excess of these general levels.

If you incur charges outside Canada on your behalf or on behalf of a covered spouse or common-law partner or child, the amounts recognized will be those that would have applied if the charges had been incurred in your province/territory of residence.

In the case of any of your children, this means that no reimbursement will be made under the plan for those services that would have been covered by a provincial/territorial dental plan if the services had been rendered in your province/territory of residence.

(b) Members serving outside Canada

When you incur expenses for a particular service or item, the plan will reimburse benefits based on the actual incurred expenses provided those amounts are considered "reasonable and customary" in that region. Any portion of an expense in excess of that "reasonable and customary" amount will not be covered under the plan. The amount that would have been incurred in Ontario for the dental procedures involved will be used in determining the annual and lifetime limits on the reimbursement of expenses, so that employees who receive treatment abroad will be in the same relative position as if they had received treatment in Ontario.

5. Pre-determination of benefits

When the estimated cost of treatment suggested by your dentist will exceed \$300, you are strongly urged to submit a treatment plan to the Plan Administrator before going ahead with these services. Upon receipt of a treatment plan, the Plan Administrator will tell you the benefits payable under the Plan for the services which are proposed in the treatment plan. Consequently, it is in your own best interest to determine what will be paid before the treatment begins.

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PART III - Claims procedure

1. Members of the Regular Force or Class C Service

If your dependants have incurred expenses that are eligible for reimbursement, you should complete an authorized claim form with the appropriate information, **showing your full name and address, including your postal code, your Plan number and your Service Number, and sign the claim form.** Claims that are found to be incomplete will be returned to you for completion. The dentist must complete his or her section on the claim form. Note that claim forms may be signed by your eligible spouse after ensuring that you are identified by your Service Number.

2. Members of the Reserve Force (Class A and Class B)

All claims for members or their eligible dependants, if admissible, must be completed with the appropriate information and approved by the Unit Orderly Room with the application of the *Pres Health Benefits Plan* approval stamp before they are submitted to the administrator.

Attach your bills or receipts, making sure they give full details for services rendered or purchases made.

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3. Duplicate protection

When your dependants' dental expenses are covered under more than one plan or under this Plan as an employee/member and a dependant, the combined reimbursement from all plans cannot exceed the expenses incurred.

(a) If you live in a province or territory that insures dental services, you should first submit your claim to the provincial or territorial authorities. When that claim has been processed, you may submit a claim to this Plan for any remaining eligible expenses.

(b) When your spouse is covered as an employee/member and also as an eligible dependant under this Plan, your spouse should first submit his or her claim to this Plan as an employee/member indicating on the claim form the Plan Number and ID Number of the Dental Care Plan which covers him or her as a dependant.

(c) When your spouse is covered as a dependant under this Plan and also under a plan with another employer, your spouse should first submit his or her claim to the other plan.

(d) When your children are covered under this plan and/or under your spouse's plan from another employer, the plan that pays first will be determined by a general agreement that insurance companies have devised. Under this arrangement, if your birthday falls earlier in the year than your spouse's, this plan will pay the children's claim first. If your spouse's birthday is earlier in the year, he or she must claim the children's dental expenses first under his or her plan.

(e) If you are a participant of this plan and of the Public Service Health Care Plan (PSHCP), you benefit from combined protection for certain types of complex surgical dental services and for dental services required as a result of injury to natural teeth.

If such services are rendered:

- i. **Because of Injury** You first submit a claim to the PSHCP. If you do not obtain full reimbursement for your dental expenses, you may then submit a duplicate of your claim form, along with a copy of the PSHCP payment summary, to the DCP.
- ii. **For Surgical Procedures** First submit your claim to the DCP and, where applicable, you may submit a claim for any unpaid expenses to the PSHCP.

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4. Claims payment

When your claim has been approved, an Explanation of Benefits will be forwarded to you by the Plan Administrator with your benefit. **Payment will be issued to you or, on signed instructions from you, may be issued to your spouse or common-law partner (Authorization to Redirect Payment form) or to the dentist (claim form).** Payments are normally made in a lump sum. However, for orthodontic services, the Plan Administrator will reimburse you on a monthly basis, provided receipts are forwarded to the Plan Administrator. The calculations for these payments will be based on the information submitted by the orthodontist on the treatment plan. [Annex D](#) provides the address of the appropriate group benefit payment office.

Claims must be submitted to the Plan Administrator within fifteen (15) months of the date on which the expense is incurred. Claims submitted after that fifteen (15) month period will not be paid unless it was impossible to submit the claim within that time. However, except in the case of legal incapacity, no claim will be paid if it is submitted more than twenty-four (24) months after the expense was incurred. (*See note below*)

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5. Claims disputes

Generally speaking, a disagreement about claims should be handled through the Plan Administrator. Occasionally, a dispute may occur about the validity of a declined claim. When all other remedies have been exhausted, the matter should be referred to the Directorate of Pensions and Social Programs (DPSP) at NDHQ, for consideration by the CF Dental Care Plan Board.

Note: For orthodontic treatment, a claim must be submitted within fifteen (15) months of the date of each monthly visit throughout the treatment period.

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ANNEX A

TABLE OF MONTHLY CONTRIBUTIONS

- Spouse only, or children only \$23.00 (as of 1 April 2000)
- Spouse with children \$46.00 (as of 1 April 2000)

ANNEX B

ELIGIBLE DENTAL SERVICES

Eligible dental services mean services listed hereafter, when rendered by a dentist or dental specialist, or rendered by a dental hygienist under the direct supervision of a dentist or dental specialist, or rendered by a dental mechanic (also referred to as a denturist or denturologist) who is licensed to provide services in the province or territory in which the service was received, and who is permitted by law to deal directly with the public. **This section should be read in conjunction with Annex C, which lists exclusions and limitations on dental services and supplies.**

Where it cannot be ascertained that the dental services rendered are covered services, the Plan Administrator will identify which of the covered services listed below could be considered to be alternative services, and will base reimbursement on those services.

Recall exams, cleaning and polishing, Top of Pageical application of fluoride and bitewing X-rays are limited to once every 9 months exactly. For example, if you are reimbursed for an exam and cleaning rendered on January 15, 2001, you will not be eligible for reimbursement of another exam or cleaning until on or after October 15, 2001. If your exam and cleaning is rendered on October 14, 2001 or earlier, the services will not be eligible.

Scaling and root planing are limited to a combined total of 6 time units per calendar year. In cases of documented periodontitis, up to an additional 6 units can be allowed in a given calendar year, with the pre-approval of a treatment plan. Consequently, if you have such a condition, you must obtain pre-approval of the required treatment for that calendar year. If additional treatment is needed in a new calendar year, a new treatment plan must be submitted. Updated documentation will be required with each request.

Membership in the Plan ends automatically on the date a person ceases to be employed or the date a person ceases to qualify as an eligible employee or dependant. In cases where a given dental treatment requiring more than one sitting began while the person was in the Plan, coverage for that treatment will continue if it is completed within 31 calendar days of the date of termination. Examples include root canal treatment (pulp chamber opened), a crown (tooth prepared and impressions taken), or ongoing active orthodontic treatment (initial appliance inserted).

DIAGNOSTIC

- **Examination and Diagnosis**
 - complete oral examination
 - recall oral examination (once every 9 consecutive months)
 - specific oral examination

- emergency oral examination
- treatment planning
- **Radiographs**
 - periapical (one complete series every 36 consecutive months)
 - occlusal
 - bitewings (once every 9 consecutive months)
 - extra-oral
 - sialography, use of dyes
 - panoramic (once every 36 consecutive months)
 - interpretation of radiographs from another source
 - tomography
- **Tests, Laboratory Examinations**
 - biopsy of oral tissue
 - pulp vitality tests

PREVENTIVE

- **Routine Services**
 - dental cleaning and polishing (once every 9 consecutive months)
 - Top of Pageical application of fluoride (once every 9 consecutive months)
 - pit and fissure sealants (for children 14 years of age and under only)
 - caries control
 - enameloplasty
 - space maintainers (not involving movement of teeth)
 - oral hygiene instructions (once per 12 consecutive months)

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RESTORATIVE

- **Minor**
 - amalgam, silicate, acrylic or composite fillings. Replacement fillings are covered only if the existing filling on the same tooth/teeth and same surface(s) is at least 24 months old.
 - pin reinforcements for these restorations
- **Major**
 - gold foil
 - gold inlays
 - retentive pins, posts and cores
 - porcelain inlays
 - crowns
 - other restorative services

ENDODONTICS

- pulp capping
- pulpotomy
- root canal therapy
- periapical services
- other endodontic procedures

PERIODONTICS

- non-surgical services
- surgical services
- post-surgical treatment
- occlusal equilibration (not exceeding 8 time units per 12 consecutive months)
- scaling and root planing (not exceeding 6 time units per 12 consecutive months)
- other periodontic services

PROSTHODONTICS

- **Minor Services for Removable Dentures**
 - repairs
 - adjustments
 - relining and rebasing (once every 36 consecutive months)
- **Major (this section should be read in conjunction with the specific limitations listed in Annex C)**
 - exams, films and diagnostic casts
 - addition of tooth to a removable denture
 - complete dentures
 - partial dentures
 - pontics (fixed bridges)
 - retainers
 - abutments (fixed bridges)
 - retentive pins in abutments
 - repairs of fixed appliances
 - other prosthodontic services

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ORAL SURGERY

- uncomplicated removal
- surgical removal and tooth repositioning
- alveoloplasty, gingivoplasty, stomatoplasty, osteoplasty, tuberoplasty
- removal of excess mucosa
- surgical excision
- removal of cyst
- surgical incision

- removal of impacted teeth
- repair of soft tissue
- frenectomy, dislocations
- miscellaneous surgical services

ORTHODONTIC SERVICES

(applies to a covered spouse and to a child under 21 years of age and to a child between the age of 21 and 25, if in full-time attendance at school or university)

- **Observation and Adjustment**
 - orthodontic exam
 - films
 - orthodontic diagnostic casts
 - surgical services
 - observation and adjustments
 - repairs, alterations

Appliances

- removable appliances
- fixed appliances
- retention appliances
- appliances to control harmful habits

ADJUNCTIVE GENERAL SERVICES

- emergency services (not otherwise specified)
- anaesthesia in connection with oral surgery and drug injections
- consultation
- house call, hospital call and special office visit

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ANNEX C

EXCLUSIONS AND LIMITATIONS

General

No benefit is payable under the DCP for the following dental services and supplies:

- services and supplies, or any portion thereof, that are covered under any provincial, territorial or other public dental, hospital or health plan under which the person is eligible;
- services and supplies, or any portion thereof, that are the legal liability of any other party;
- services and supplies rendered or provided to which a person is entitled without charge pursuant to any law, including, but not limited to, Workers' Compensation or similar law, or for which there is no cost to the person except for the existence of insurance against such cost;
- services and supplies received in a hospital owned or operated by a government, unless the person is required to pay for such services or supplies regardless of the existence of insurance;

- e. services and supplies rendered outside Canada to persons residing in Canada, or to children of a member residing in Canada, which would be payable under a provincial or territorial health, dental or hospital plan if the services had been rendered in Canada;
- f. dental treatment involving the use of precious and non-precious metals, if such treatment could have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice, except for that portion of expenses that would have been incurred for treatment by means of a reasonable substitute;
- g. user fees, co-insurance charges or similar charges which are in excess of charges payable by a government dental, hospital or health plan;
- h. dental treatment that is not yet approved by the Canadian Dental Association or dental treatment that, in the opinion of the Plan Administrator, is clearly experimental in nature;
- i. services and supplies, that, in the opinion of the Plan Administrator, are rendered principally for cosmetic purposes including, but not limited to, porcelain or composite facings on crowns or pontics on molar teeth;
- j. services and supplies related to the purchase, repair, modification or replacement of a duplicate prosthodontic appliance, for any reason;
- k. services rendered and supplies purchased before the date the person became covered under this Plan;
- l. charges for an appliance or a modification of one where an impression is made for such appliance or a modification before the person became covered under this plan; charges for crowns, bridges and gold restorations for which a tooth was prepared before the person became covered under this plan; charges for root canal therapy where the pulp chamber was opened before the person became covered under this plan;
- m. services and supplies rendered as a result of a congenital or developmental malformation which is not a Class I, II or III malocclusion in patients 19 years of age or over;
- n. charges for a periodontal appliance, occlusal equilibration, and other related services as a result of a temporo-mandibular joint dysfunction (TMJ dysfunction) or vertical dimension correction; and
- o. implants.

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Specific limitations with respect to major services

Services for the installation of prosthodontic appliances (for example, fixed bridges, pontics and abutments, temporary or permanent, partial or complete dentures) constitute eligible dental services only if they are rendered for:

- a. an initial prosthodontic appliance, or
- b. the replacement of an existing prosthodontic appliance, including the addition of teeth to an existing appliance, if
 - i. the replacement or the addition of teeth is required because at least one additional natural tooth was extracted after the insertion of the existing appliance, and the appliance could not have been made serviceable. If the existing appliance could have been made serviceable, only the expense for that portion of the replacement appliance that replaces the teeth extracted shall be covered;
 - ii. the existing appliance is at least five (5) years old and cannot be made serviceable (irrespective of who paid for the existing appliance);
 - iii. the existing appliance was temporarily installed, provided that the replacement appliance is installed within twelve (12) months of insertion of the temporary appliance and that such replacement appliance will thereafter be deemed permanent for the purposes of this provision;

Effective January 1, 2004: When a temporary prosthodontic appliance is installed as part of major restorative services, plan coverage for permanent prosthodontic appliances will be provided without regard to when the temporary appliances was first installed provided that the person was covered under the plan when the temporary appliance was installed. This removes the 12-month limitation on the replacement of temporary prosthodontic appliances.
 - iv. the replacement appliance is required as a result of the installation of an initial opposing denture after the date the person becomes covered under the plan; or (v) the replacement appliance is

required as a result of accidental dental injury to a natural tooth that occurred after the date the person became covered under the plan.

- v. the replacement appliance is required as a result of accidental dental injury to a natural tooth which occurred after the date the person became covered under the Plan.

Effective January 1, 2004:

The necessary replacement of fillings (same tooth and surface) will be paid under this plan once every 24 months irrespective of the age of the filling. The necessary replacement of crowns will be paid under this plan once every 60 months irrespective of the age of the crown. This assures coverage for fillings and crowns on initial treatment under the Plan.

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ANNEX D

CLAIMS OFFICES

All claims should be sent to:

**Canadian Forces Dependents Dental Care Plan, The Great-West Life Assurance Company
at the appropriate group benefit payment office, as indicated below:**

Winnipeg (Members posted outside Canada)

Foreign Benefit Payments Office
P.O. Box 6000
Winnipeg, Manitoba
R3C 3A5
Tel: English & French - (204) 942-3589
Toll-free line - English - 1-800-957-9777
French - 1-800-704-4007

Montreal (Quebec Residents other than National Capital Region)

Montreal Benefit Payment Office
P.O. Box 400
40 Dolbeau
Place Bonaventure
Montreal, Quebec
H5A 1B9
Tel: English & French - (514) 878-1288
Toll-free line - French and English - 1-800-663-2817

Winnipeg (Other Canadian Residents - including the National Capital Region)

Health and Dental Claims Centre
P.O. Box 6025
Station Main
Winnipeg, Manitoba
R3C 3C7
Tel: English & French - (204) 942-3589
Toll-free line - English - 1-800-957-9777
French - 1-800-704-4007

Claim Forms

- [Claim form for CF Dependents Dental Care Plan](#) - (pdf format 54k)
- [Claim form for CF Reserve \(Class A and B service\) Dental Care Plan](#)
- (pdf format 54k)

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