

**DENTAL BENEFITS AT A GLANCE**  
**COMPARISON OF DENTAL SERVICES COVERED UNDER**  
**THE DENTAL PLAN VERSUS EXTENDED HEALTH CARE PLAN 2 (EHC PLAN 2)**

COVERED EXPENSES	DENTAL PLAN	EHC PLAN 2 Covered Dental Expenses
<b>DEDUCTIBLE</b>	Nil	Nil
<b>REIMBURSEMENT</b>		<b>No Coverage unless noted below</b>
<b>Basic</b>	100%	
<b>Endodontic</b>	100%	100%
<b>Periodontal</b>	100%	100%
<b>Dentures</b>	100%	100%
<b>Crowns</b>	50%	50%
<b>Bridges</b>	50%	50%
<b>Inlays &amp; Onlays</b>	50%	50%
<b>Orthodontics</b>	50%	<b>No Coverage</b>
<b>MAXIMUMS</b>	\$2,000 per person per calendar year for basic, endodontic, periodontal & dentures \$2,000 per person per calendar year for crowns, bridges, inlays and onlays \$2,500 per person lifetime for orthodontics	<b>\$2,000 per person per calendar year for all services combined</b>
<b>COVERED FEE</b>	Fee stated in the Ontario Dental Association Fee Guide for General Practitioners – one year prior to the date the expense is incurred	Same
<b>PRE-DETERMINATION</b>	Recommended for expenses in excess of \$300	<b>Mandatory as only major dental services are covered</b>
<b>BASIC SERVICES</b>	Fillings, space maintainers for missing primary teeth, fluoride, polishing, protective athletic appliances, caries, trauma and pain control  Anaesthesia	<b>No Coverage</b>  <b>Included when required in conjunction with covered expenses</b>

<b>COVERED EXPENSES</b>	<b>DENTAL PLAN</b>	<b>EHC PLAN 2 Covered Dental Expenses</b>
<b>BASIC SERVICES (cont')</b>	<p>Extraction of teeth</p> <p>Examinations including:</p> <ul style="list-style-type: none"> <li>- initial examinations</li> <li>- recall examinations</li> <li>- emergency or specific examinations</li> </ul> <p>Consultations with another dentist, retentive pins, prefabricated full coverage restorations</p> <p>X-rays including</p> <ul style="list-style-type: none"> <li>- 1 complete series of x-rays or 1 panorex every 24 months</li> <li>- bitewing X-rays and specific diagnostic X-rays</li> </ul>	<p>- <b>Extractions directly relating to crown, bridge and denture services.</b></p> <p style="text-align: center;"><b>No Coverage</b> <b>No Coverage</b> <b>No Coverage</b></p> <p><b>Included but only those directly relating to covered expenses</b></p> <p style="text-align: center;"><b>No Coverage</b> <b>No Coverage</b></p>
<b>ENDODONTIC SERVICES</b>	Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue	Included
<b>PERIODONTAL SERVICES</b>	Treatment of disease of the gum and other supporting tissue	Included
<b>DENTURE SERVICES</b>	Complete upper and lower dentures limited to once every three years; Partial dentures limited to once every three years; Denture adjustments, repair, relining and rebasing of existing partial or complete dentures Laboratory fees associated with denture services.	Included
<b>BRIDGES, CROWNS, INLAYS, ONLAYS</b>	Bridges and crowns including repairs; inlays, onlays and pins in inlays; post and core	Included
<b>ORTHODONTIC SERVICES</b>	Examinations, diagnosis, consultations, appliances and other services for the straightening of the teeth	<b>No Coverage</b>

**NOTE:**

If you do not elect coverage under the Dental Plan at your retirement date, the Dental Plan is no longer available to you at any future date with one exception. If you have dropped/waived the dental coverage because you are covered under your spouse's/partner's employer's group plan, you may join the Colleges' benefit plan within 31 days of losing the coverage under your spouse's/partner's plan. Proof of the loss of coverage will be required by your college benefits plan administrator.