

# RTO/ERO Dental Plan

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## When Does Coverage Begin

You may enroll without late applicant coverage limitations provided Johnson Inc. Plan Benefits Service receives your application within 60 days of the termination date of your school board group insurance plan, your spouse's group insurance plan or any other group insurance plan. Your coverage must be continuous and will be in effect the day following the termination date of your previous group insurance regardless of when your application is received within the 60 day period.

If you apply after the 60 day eligibility period, are transferring from an individual insurance plan, or were not previously insured under a group insurance plan, you will be considered a "late applicant".

## Applying for the Dental Plan as a "late applicant"

Your coverage will begin on the date Johnson Inc. receives your completed application. As a late applicant, the maximum benefit payable during the first 12 months of coverage will be limited to \$500 per insured person.

## Changes to your status

**It is your responsibility to notify Johnson Inc. Plan Benefits Service, in writing, when there is a change in your coverage status** (e.g., from family to couple or from single to couple).

**Adding Dependents:** If, after your effective date of coverage, you acquire a spouse and/or any dependent children, you must enroll your dependent(s) within 60 days of the life event; otherwise, the late applicant conditions outlined above will apply. If a dependent is hospitalized on the date coverage would normally become effective, your dependent's coverage will be postponed until the day following discharge from the hospital. If you already have family coverage, new dependents are automatically covered regardless of hospital confinement.

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## What is Covered under the Dental Plan

All reimbursements are based on the suggested fees of the 2016 Dental Association Fee Guide for General Practitioners (GP). Reimbursement is based on the province where dental services are performed for the least expensive treatment that will provide a professionally adequate result. Specialist fees in excess of General Practitioner fees will not be reimbursed and are your responsibility. The reasonable and customary charge for laboratory expenses is defined as being no more than 80% of the 2016 Dental Association Fee Guide for General Practitioners in the province where services are rendered. Laboratory expenses are reimbursed at the same level as the procedure to which they pertain and are included in the benefit limits.

Eligible procedures must be performed by a Dentist, Denturist or Dental Hygienist.

**Dental coverage outside of Canada:** You are covered for eligible dental treatment required while travelling outside of Canada. These expenses will be reimbursed on the same basis as similar expenses within your province of residence. An invoice, signed by the dentist, which details the services provided, including pre-treatment x-rays and/or a letter of expertise, will be required.

**Treatment plan:** If dental work is expected to exceed \$600, you should submit a detailed pre-treatment plan to Johnson Inc. Plan Benefits Claims, before the work begins, to determine the amount you may be reimbursed from the plan. For major restorative treatment, the pre-treatment radiograph will be required. This suggestion is not intended to limit you in your choice of dentist, to tell you or your dentist what treatment should be performed, to tell the dentist what fee to charge, nor to guarantee reimbursement after coverage ceases.

## Eligible Benefits

### 1. Basic and Preventive

Reimbursement: 85%

The plan covers:

- a) Once every nine months: standard oral examinations, recall oral examinations, one unit of polishing, oral hygiene instruction and topical fluoride application;
- b) Complete oral examination and diagnosis, once every three consecutive calendar years;
- c) Dental x-rays, except bitewing x-rays that are limited to once every nine months, and full-mouth and panoramic x-rays that are each limited to once every three consecutive calendar years;
- d) Dental consultations;
- e) Acid etch space maintainers;
- f) Amalgam and composite fillings. Fillings on molar teeth are limited to the cost of amalgam fillings;
- g) Veneer applications;
- h) Retentive pins;
- i) Surgical extractions of erupted and impacted teeth and removal of residual roots;
- j) Surgical removal of tumours and cysts; incision and drainage of abscesses;

- k) General anesthesia based on reasonable and customary limits for the services performed; and
- l) Relining, rebasing and repair of existing partial or complete dentures.

## 2. Endodontic and Periodontic

Reimbursement: 80% to a maximum combined limit of \$850 per insured person per calendar year

The plan covers:

- a) **Endodontics:** Treatment of dental pulp diseases, including root canal therapy. Exceptional, calcified, and difficult access root canals require pretreatment x-ray. Retreatment performed by a GP also requires a pre-treatment x-ray; and
- b) **Periodontics:** Treatment of bones and tissues supporting teeth, including surgery, provisional splinting and occlusal equilibration.
  - Periodontal cleaning limited to a maximum of eight units of scaling per calendar year;
  - Occlusal equilibration limited to \$250 per insured person per calendar year; and
  - Grafts, periodontal flap surgeries, guided tissue regeneration procedures are eligible if not performed in connection with an implant.

## 3. Major Restorative

Reimbursement: 50%

The plan covers:

- a) **Combined limit of \$800** per insured person per calendar year for crowns, posts, onlays and inlays (including any related laboratory charges) used to restore teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or tooth-coloured fillings, benefits will be determined based on the usual costs of such a filling.
  - Replacement crowns, limited to once every three consecutive calendar years;
  - Crowns on molar teeth, limited to the cost of metal crowns; and
  - A permanent crown placed on an implant.

Any amounts reimbursed for a temporary crown on a natural tooth or implant will be deducted from the amount reimbursed for the permanent crown on a tooth or implant.

- b) **Combined limit of \$800** per insured person per calendar year for initial installation or repair of permanent bridges and initial installation of permanent partial dentures including those placed on an implant (including any related laboratory charges).

Replacement of an existing permanent bridge or permanent partial denture will be considered if:

- Necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
- The existing bridge or partial denture cannot be made serviceable, and the existing bridge is at least three years old, or the existing partial denture is at least five years old; or

- The existing bridge or partial denture is temporary and is replaced by a permanent bridge or partial denture within twelve months of its installation.

A temporary appliance which is at least 12 months old will be considered to be a permanent partial denture or bridge for the purposes of this provision and is subject to same frequency.

Any amounts reimbursed for the transitional or temporary partial denture and/or temporary bridge will be deducted from the amount reimbursed for the permanent appliance.

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## Exclusions

The following are general exclusions and limitations applicable to the RTO/ERO Group Insurance Plans. This insurance does not cover any expenses for the following:

1. Expenses covered under a government plan (e.g., Provincial/Territorial Government Health Insurance Plans, Workers Compensation), or which a government plan prohibits from being paid;
2. Tests, procedures or treatment methods not recognized by Health Canada, the Provincial Health Ministry, the Canadian Medical Association, the Canadian Dental Association or the appropriate specialty society which are considered experimental or cosmetic in nature;
3. Drugs, sera, injectibles and supplies not approved by Health Canada (Food and Drug), or that are experimental or limited in use whether or not so approved;
4. Charges for medical services that are not medically necessary;
5. Insurance premiums;
6. Charges in excess of the RTO/ERO Group Insurance Benefits maximums;
7. Charges in excess of the reasonable and customary charge for the area in which the expense was incurred;
8. Charges by a physician for services rendered (except those pre-approved by Allianz Global Assistance while travelling outside your province of residence);
9. Charges by a physician, dentist, or health provider for travel time, missed or cancelled appointments, transportation costs, completion of insurance forms or physician's notes, room rental charges or charges for consultation or prescription renewals;
10. Expenses for which there would be no charge except for the existence of coverage;
11. Charges for transport or travel, other than as specifically provided under eligible expenses;
12. Gratuities and tips;
13. Point program redemptions of any type, (e.g., AIR MILES® reward miles, Aeroplan®, timeshare points/weeks) used to purchase items or services and any charges to reinstate the points;
14. Charges for maintenance, exchange or timeshare fees;

15. Charges for replacement of drugs or existing appliances previously reimbursed under the RTO/ERO Group Insurance Benefits that have been lost, mislaid or stolen;
16. Examinations and physician notes/forms required for third-party use;
17. Accommodation charges in a rest home, nursing home, health spa, a place for custodial care, a home for the aged, or a facility that is primarily operated as a place for the care and treatment of alcoholism, drug addiction or mental illness; and
18. Any expenses incurred directly or indirectly as a result of the following:
  - a) While sane or insane, injuries and/or illness that are intentionally self-inflicted and attempted and/or committed suicide;
  - b) Cosmetic surgery or treatment unless it is due to an accidental injury and it began within 90 days of the accident;
  - c) Insurrection, war, service in the armed forces of any country, or participation in a riot, or hostilities of any kind;
  - d) Your participation as a professional athlete in a sporting event and/or participation in underwater activities, in scuba-diving as an amateur (unless licensed). Your participation in any of these: motorized race or speed contest, bungee jumping, parachuting, parasailing, rock climbing, mountain climbing, hang-gliding, skydiving, or any other hazardous activities;
  - e) An accident or injury while impaired by alcohol with an alcohol concentration that exceeds 80 milligrams in 100 milliliters of blood; or
  - f) Committing or attempting an assault or criminal offence.

In addition to the above general exclusions and limitations, the Dental Plan does not cover any expenses incurred directly or indirectly as a result of or for the following:

1. Installation or replacement of complete dentures;
2. Services or supplies that are not furnished by a legally qualified dentist, dental hygienist or denturist acting within the scope of their license and/or accreditation or a dental student working under the supervision of a licensed eligible practitioner;
3. Services or supplies in connection with any procedures excluded as eligible expenses;
4. Services or supplies for or in connection with orthodontic treatment;
5. A replacement filling within 12 months of the initial filling on same tooth and same surface(s);
6. Services or supplies for full-mouth reconstruction, vertical dimension correction, services related to or correction of temporomandibular joint (TMJ) dysfunction;
7. Charges for dental treatment received from an employer, association, or labour union maintained health or dental departments; and
8. Services or supplies for implantology and/or preparation for implant placement, including tooth implantation or transplantation and surgical insertion of fabricated implants, except for prosthetic devices, such as a crown, partial denture, or bridgework. Repayment will be requested for any services performed and reimbursed under this plan where a future implant is placed.

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## How to Submit a Claim

All claims must be submitted no later than the end of the calendar year following the year in which the expenses were incurred. For example, all claims incurred in 2015 must be submitted by December 31, 2016.

- Dental offices can electronically submit your dental claim directly to Johnson Inc. Plan Benefits Claims. Please do not submit a paper claim form if your dental office has confirmed successful electronic submission.
- If your dentist is unable to file electronically, have your dentist complete “Part 1 Dentist” of the standard dental claim form provided by the dental office. You must complete “Part 2” of the claim form, including the Plan Number 983431 and your identification number (ID#), and submit your claim to Johnson Inc. Plan Benefits Claims.
- Payments are always made directly to you. You are responsible for settling your account with your dentist.
- Pre-treatment estimates and any dental claims for major dental work, that has not been pre-approved or that requires x-rays, must be submitted as a paper claim.

### Coordination of benefits with other plans:

If you are covered under more than one group plan simultaneously, benefit payments from all plans will be coordinated so that the total does not exceed the actual expense incurred. Your claims should be submitted first to this plan, your spouse’s claims should be submitted first to his/her plan, and your dependent children’s claims should be submitted first to the plan of the parent whose birthday (i.e., month and day) occurs earlier in the calendar year.

A copy of the explanation of benefits from the other insurance carrier, photocopies of all receipts and a completed Group Benefits Program claim form, are required for consideration of the claim balance. If the other plan under which you are covered does not have a coordination of benefits provision, claims should be submitted first to that plan. If priority cannot be established by those means, benefits will be pro-rated between the plans.

All coordination of benefits follows the Canadian Life and Health Insurance Association coordination of benefits guidelines.

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## When Does Your Coverage Terminate

Your coverage ceases on the earliest of the following events:

- You request in writing to terminate coverage;
- You cease to make premium payments;
- You cease to be an RTO/ERO member; or
- The plan is terminated.

**Please note:** Your dependents’ coverage ceases on the earliest of the above events or when they are no longer eligible

You may be eligible for a refund of pre-paid premium based on your date of cancellation or status change.

**Survivor coverage after your death:** Following notification of your death, Johnson Inc. Plan Benefits Service will send an RTO/ERO Membership and Continuation of Benefits Form for completion. Once received, coverage for your spouse and/or dependent children may be continued for as long as premiums are paid and they continue to qualify for coverage.

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### Monthly Premium Rates (Effective January 1, 2016)

Plan	Single	Couple	Family
Dental	\$56.50	\$111.42	\$138.94

Where required by law, Retail Sales Tax will be added to these premium rates.

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### Contact Information

If you have any questions concerning the RTO/ERO Group Insurance Plans, or claims inquiries, please call:

<p><b>Johnson Inc.</b> <b>Plan Benefits Service</b> 18 Spadina Road, Suite 100A Toronto ON M5R 2S7 416-920-7248 (Toronto area) 1-877-406-9007 (toll free) 416-920-0939 (fax) healthbenefits@johnson.ca (email) www.johnson.ca/rto-ero</p>	<p><b>Johnson Inc.</b> <b>Plan Benefits Claims</b> 1595 16th Avenue, Suite 700 Richmond Hill ON L4B 3S5 905-764-4888 (Toronto area) 1-800-638-4753 (toll free) 905-764-4041 (fax) pbclaimsonario@johnson.ca (email) www.johnson.ca/rto-ero</p>
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