

# TEAMSTERS' NATIONAL BENEFIT PLAN - COVERAGE LEVEL A

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Revised September 1, 2011

## **INTRODUCTION**

The Plan became effective July 1, 1971, as the result of a Collective Agreement between certain employers and the Union. The Plan operates under the supervision and guidance of a Board of Trustees appointed by the Teamsters Local Union No. 31.

The Trustees operate under an Agreement and Declaration of Trust originally dated July 1, 1971 and revised November 1, 1991.

### **Board of Trustees:**

Mr. Stan Hennessy  
Mr. Rod Blackburn  
Mr. Terry Tyler

### **Administration and Claims Office:**

Teamsters' National Benefit Plan,  
1610 Kebet Way,  
Port Coquitlam, B.C. V3C 5W9

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This booklet can be viewed online at [www.teamsters31.ca](http://www.teamsters31.ca)

### **Consultant and Actuary:**

Morneau Shepell

*The purpose of this booklet is to give you a brief description of the Plan and its benefits in general terms. It is not to be considered a contract of insurance. The exact terms of the benefits are detailed in insurance contracts and other formal documents which govern the Plan. Benefits are subject to change by the Trustees.*

## SUMMARY OF BENEFITS

- Group Life Insurance \$50,000
- Accidental Death, Disease & Dismemberment  
Principal Amount \$60,000
- Dental see pg 18
- Extended Health see pg 8
- Weekly Indemnity 75% of pre-disability  
earnings to a maximum weekly benefit of \$500
- Long Term Disability (monthly) \$1,000

### **BENEFITS ARE UNDERWRITTEN BY THE FOLLOWING:**

#### **Great West Life Assurance Company**

Group Life  
Policy No. 325335

#### **Chartis Insurance Company of Canada**

Accidental Death, Disease and Dismemberment  
Policy BSC 9112494

#### **Teamsters' National Benefit Plan**

Dental (self insured)  
Extended Health (self insured)  
Weekly Indemnity (self insured)  
Long Term Disability (self insured)

## **ELIGIBILITY PROVISIONS**

### **Eligible Employees**

- Union Members

You must be a member in good standing of Teamsters Local Union No. 31 and a regular employee or dependent contractor of a participating company. Participation in the Plan is compulsory.

- Non-Union Members

The salaried non-Union employees of a participating employer who have signed a participation agreement are eligible, provided that at least 90% of all non-Union employees participate. Any employee who does not join the Plan when first eligible will be required to produce satisfactory evidence of insurability at their own expense to join at a later date. All other provisions of the Plan will apply equally to Union and non-Union members.

### **Eligible Dependents**

- Your spouse or common-law spouse with whom you reside;
- Your or your spouse's unmarried child under the age of 19 provided the child relies principally upon you for support and resides with you;
- Your or your spouse's unmarried child under the age of 25 provided the child is in full-time attendance at a recognized school, college or university, relies principally upon you for support and normally resides with you;
- Your or your spouse's unmarried child of any age who is mentally or physically handicapped to the extent that such child is incapable of self support provided the child relies principally upon you for support and resides with you may be covered for EHB and dental benefits only.

In the event that you are legally separated or divorced and the courts order you to provide coverage for your dependents, dependents shall include:

- Any child who resides with your former spouse and meets all other conditions of being a dependent, and
- A former spouse, provided you have not appointed another spouse.

Please note the Plan must be provided with a copy of the court document to determine eligibility requirements.

## Effective Date

Coverage for you and your eligible dependents will become effective on the first day of the month coincident with or following the date on which you become an eligible employee as determined in the Collective Agreement between the Union and your employer provided you are actively at work on that date. If you are not actively at work on that date, coverage will commence on the first day that you return to active work.

## Termination of Coverage

### A. Dental, Extended Health (E.H.B.), Group Life and A.D.& D.

Coverage for you and your eligible dependents will terminate on the last day of the month in which you cease to be actively employed by a participating employer, except:

- if disabled, coverage may continue (pursuant to the terms of your collective agreement) for a maximum 12 month period provided contributions are paid by your employer;
- if a grievance is invoked upon termination of employment, coverage may continue (pursuant to the terms of your collective agreement) during the period to a maximum of 12 months provided contributions are paid by your employer;
- if your death occurs while you are covered, coverage will continue for your dependents for 12 months following the last day of the month in which your death occurs;

**E.H.B. Coverage for Long Term Disability Claimants.** If you became disabled on or after January 1, 1989 and are continuing to receive Long Term Disability benefits (L.T.D.) under this Plan, you will continue to receive E.H.B. coverage for the duration of your Long Term Disability claim at no cost to you. Continuation of this benefit is subject to approval by the Trustees. If death occurs while receiving L.T.D. benefits, E.H.B. coverage will continue for your dependents for 12 months following the last day of the month in which your death occurs.

## B. Weekly Indemnity and Long Term Disability Benefits

Coverage for the weekly indemnity and long term disability benefits and the disability waiver provisions of the group life and A.D.& D. benefits will terminate immediately if your employment terminates, you are laid off or you incur any other temporary cessation of active employment with a participating employer, except:

- if layoff or any other temporary interruption of employment occurs and you become disabled within 31 days of the date last worked you may be eligible for weekly indemnity or long term disability benefits commencing with the date you would have returned to work. If you are receiving E.I. benefits, WI or LTD benefits will not be payable until E.I. benefits cease.
- if you become disabled during a strike or lock-out within 6 months of the date last worked, you may be eligible for weekly indemnity or long term disability benefits commencing with the date you would have returned to work. If you are receiving E.I. benefits, WI or LTD benefits will not be payable until E.I. benefits cease.

### Continuing Benefits (Self Pay Provision)

If your coverage under the Plan terminates you may personally apply to continue coverage for a maximum of 12 months for E.H.B., group life and A.D.& D. If your employer has been providing basic medical (M.S.P.) coverage through the Plan, you may continue this coverage as well. **Application must be received within 30 days of coverage terminating** and subsequent payments must be received by the 15th of each month. Continuing Benefits are not available if:

- you have attained age 65. or;
- you are totally disabled and receiving Long Term Disability benefits under this Plan. (The Plan currently provides group life, A.D.& D. and Extended Health Benefits at no cost to members who are in receipt of Long Term Disability Benefits from the Plan.)

To qualify for Continuing Benefits you must remain a member of the Union in good standing.

This coverage **does not** include **weekly indemnity, long term disability or dental benefits.**

## **Reinstatement of Coverage**

If you are laid off and return to work with the same employer as a regular employee for one full shift (unless other conditions are specified in the Collective Agreement) coverage for E.H.B. and dental benefits for you and your eligible dependents will be reinstated retroactively to the first day of the calendar month in which you return to work. Your weekly indemnity, long term disability, group life and accidental death, disease and & dismemberment coverage will be reinstated as of the day you return to work.

## **Application Forms**

Your employer has a supply of Member Data forms for you to complete for participation in the Plan. The form(s) should be completed and returned to your employer who will submit them to the Administrator. If your employer is providing medical coverage (M.S.P.) through the Plan, you must also complete an M.S.P. application or, if you have medical coverage privately, you must complete a form in which you waive entitlement to this coverage.

## **EXTENDED HEALTH BENEFIT (EHB)**

This benefit is designed to assist you in paying for certain services and supplies not covered under the government's basic medical coverage, the Medical Services Plan of British Columbia and the Hospital Programs of B.C. The Plan covers reasonable and customary charges for eligible expenses for you and your eligible dependents when required for the treatment of accident, illness or disease. You should be aware that the prices charged by suppliers of services or equipment may vary considerably. We suggest that, whenever practical, you should compare prices.

### **Deductible**

The Plan has a \$2.00 per prescription deductible on pharmaceuticals.

### **Maximum Benefit**

The maximum benefit payable for prescription drugs in any calendar year is \$2,000. per family. Coverage for other benefits is unlimited for you and your eligible dependents unless specified under the section entitled "Eligible Benefits".

### **Co-ordination of Benefits**

In the event that an eligible person is also entitled to benefits under any other group insurance program or insurance policy, benefits will be co-ordinated with the other plan or insurer to ensure that the total benefit paid from all sources does not exceed 100% of the reasonable charges for the services and supplies provided.

If your spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association. These guidelines are used by most, if not all, insurers in Canada.

We are the primary insurer for your expenses. Your spouse's insurer is the primary carrier for your spouse's expenses. Dependent children become the primary responsibility of the plan who insures the parent who has the earliest birth date in the year (month and day).

If the Plan is the secondary carrier, please remit copies of receipts paid by the primary carrier along with their statement of payment details.

**In the event of marital breakup, coverage for dependents varies depending upon custody and other coverage in effect. Please contact the Plan for further details.**

## **Pharmacare**

The Provincial Fair Pharmacare programs provides 70% coverage for eligible prescription medications included under their “formulary” once their annual deductible (based on family income) has been reached. If you have reached the Pharmacare deductible, the Plan will continue to pay any portion not covered by Pharmacare (less the \$2.00 prescription fee) provided you have not reached the Plans \$2,000. annual family limit.

**IMPORTANT --- The Fair Pharmacare program is based on income and it is necessary for you to make application to them for coverage. Proof of registration will be issued by Fair Pharmacare. It will be necessary for you to provide proof of registration to the Plan before your drug card will be activated and before any prescription drugs will be eligible for reimbursement.**

## **Eligible Expenses - In Province (reimbursed at 80%)**

- 1) Drugs approved for sale in Canada for the treatment of illness or disease which are available only by prescription and when prescribed by a Physician with the exception of drugs determined by the Trustees to be “lifestyle” drugs. Lifestyle drugs are described under the “Exclusions” section of the booklet on page 14.
  - Unless your doctor specifically requires that no substitutions be used, the Plan will pay for the generic equivalent of name brand drugs.
  - The Plan has a 90 day supply limit on all prescription drugs.
  - If a drug could be covered by Pharmacare under its “special authority” provision, we advise you have your doctor apply to Pharmacare for Special Authority. If Pharmacare approved, this amount will be then applied to your Pharmacare deductible. Please ask your pharmacist for further details.
- 2) Chiropractor - customary fees not exceeding \$40 per visit of a licensed chiropractor to a maximum benefit of \$350 per person, \$750 per family per calendar year (x-rays excluded).

- 3) Naturopath - customary fees not exceeding \$40 per visit of a licensed naturopath to a maximum benefit of \$350 per person, \$750 per family per calendar year, (testing fees, x-rays and medication excluded).
- 4) Physiotherapist - customary fees not exceeding \$40 per visit of a licensed physiotherapist to a maximum benefit of \$350 per person, \$750 per family per calendar year.
- 5) Massage Therapist - customary fee not exceeding \$40 per visit of a licensed massage therapist to a maximum benefit of \$350 per person, \$750 per family per calendar year.
- 6) Podiatrist - customary fees not exceeding \$40 per visit of a licensed podiatrist to a maximum benefit of \$350 per person, \$750 per family per calendar year (x-rays and appliances excluded).
- 7) Licensed Psychologist or Registered Clinical Counsellor – counselling with a licensed psychologist or registered clinical counsellor to a maximum per visit fee of \$60 to a combined maximum benefit of \$350 per person, \$750 per family per calendar year.
- 8) Speech Therapist – customary fees not exceeding \$40 per visit of a licensed speech therapist to a maximum benefit of \$350 per person, \$750 per family per calendar year.
- 9) Acupuncturist - customary fees not exceeding \$40 per visit of a licensed acupuncturist to a maximum benefit of \$350 per person, \$750 per family per calendar year.
- 10) Registered Nurse - when referred - customary fees to a maximum of \$10,000 per calendar year. Must not be a relative or residing with you.
- 11) Crutches, Artificial Limbs and Eyes, Oxygen, Blood or Blood Plasma - when prescribed by a physician.
- 12) Charges for certain ostomy and ileostomy supplies and materials as determined by the Trustees from time to time.
- 13) Custom made Air Casts, Splints, Trusses, Braces, when prescribed by a physician up to a maximum of once in any 24 consecutive month period.
- 14) Cryocuffs when prescribed by a physician immediately following surgery to a maximum benefit of \$250 per calendar year.

- 15) C.P.A.P. machine or Mandibular Repositioning appliance when prescribed by a physician for the treatment of sleep apnea to a combined maximum benefit of \$1,600 in any consecutive 36 month period. C.P.A.P. masks, equipment, hoses and fittings once every 12 months (filters excluded).
- 16) Custom made Orthopaedic Shoes - when prescribed by a physician – maximum benefit of \$150 per pair per person - limit 2 pair per year.
- 17) Custom Made Foot Orthotics - when prescribed by a physician, chiropractor or podiatrist – maximum benefit of \$200 per person in any 24 consecutive month period (for dependent children to a maximum benefit of \$200 per person in any consecutive 12 month period)
- 18) Charges for support hose when prescribed by a Physician limited to two (2) pair per calendar year.
- 19) Wigs and Hairpieces - when required as a result of medical treatment or accident - maximum benefit of \$500 per person per lifetime.
- 20) Mastectomy Protheses - maximum 1 (per side) in any 24 consecutive month period.
- 21) Brassieres - following purchase of initial protheses to a maximum benefit of \$150 per calendar year.
- 22) Rental or purchase of Wheelchair, Hospital Type Bed, Oximeter, etc. - when prescribed by a physician (reimbursement will not exceed total purchase price). Limited to once every 36 consecutive months. Please contact Plan for further details as prior approval may be required for some durable equipment.
- 23) Hearing Aids to a maximum benefit of \$500 for each ear during any 36 consecutive month period.
- 24) Assistive Listening Devices to a maximum benefit of \$400 limited to one per lifetime.
- 25) Prescription Eyeglasses, prescription Contact Lenses or fees for Corrective Laser Eye Surgery, when prescribed by a physician to a maximum combined benefit of \$250 per person in any 24 consecutive month period.

- 26) Eye examinations by a licensed optometrist to a maximum benefit of \$50 in any 24 consecutive months,  
(Subject to Exclusion and Limitations 1).
- 27) TNS Equipment – when prescribed by a physician to a maximum benefit of \$400 per person per lifetime.
- 28) Glucometers – when prescribed by a physician to a maximum benefit of \$200 per person in any 36 consecutive month period.
- 29) Insulin Pumps when prescribed by an endocrinologist to a maximum benefit of \$1,600 in any 60 consecutive month period.
- 30) Blood Pressure Monitors – when prescribed by a physician to a maximum benefit of \$100 per person in any 36 consecutive month period.
- 31) Ambulance service in an emergency, and when recommended by a Physician, return fare for transportation of the Member or Dependent requiring treatment by ambulance, railroad, boat or airplane, and in an acute emergency by air ambulance, from the place where the Sickness or Injury occurs to the nearest Hospital, including the return fare of 1 attending Physician, nurse or first aid attendant, or a parent of a Dependent child, where such person is necessary to care for the patient during transport
- 32) Dental services included as Covered Procedures under the Dental Benefit portion of the Plan, required as the result of an accident and performed by a dentist for the restoration, repair or replacement of natural teeth. To be eligible, treatment must occur within one year of the date of injury and must not be the result of a motor vehicle accident in the Province of British Columbia.
- 33) Hospital charges for out patient, emergency ward and short stay facilities.
- 34) Hospital room differential for private and semi-private accommodation.
- 35) Pulse monitoring equipment on a once per lifetime basis to a maximum of \$150, when prescribed by a physician in conjunction with a prescribed heart therapy program.

## **Treatment for Substance Abuse**

The Plan will pay 100% of the treatment fees in a residential treatment centre, licensed by the Province of British Columbia or the Yukon Territories at the normal cost for such treatment as recognized by those governments to a maximum benefit of \$4,500. This benefit is available once per lifetime. Payment will be made directly to the residential treatment facility. This benefit is available to members only - not dependents.

## **Eligible Expenses - Out of Province – 6 Week Maximum per out of Province visit**

Eligible expenses shall include **reasonable and customary charges incurred during the first six weeks of absence from the Member's Province of residence** for the following expenses as the result of an emergency outside the Province while travelling or on vacation, to the extent that such expenses are not payable or provided under or pursuant to Medical Services Plan of B.C., the Hospital Programs of B.C., Pharmacare, any other medical plan or plan of insurance, any Hospital Program or Workers' Compensation Act or by any public or tax supported authority or agency:

- 1) Charges of a hospital for services, medical supplies, co-insurance and short term stay facilities, ward accommodation and any additional charge for private or semi-private room actually occupied if ward accommodation is not available or if required by a Physician, but not charges for the rental of telephones, televisions, radios or similar equipment.
- 2) Fees of Physician and charges for laboratory and x-ray services when ordered by a Physician.
- 3) Charges for drugs available only by prescription when prescribed by a Physician but only in sufficient quantity to alleviate an acute medical condition.
- 4) Charges for local ambulance service to provide transportation to the nearest hospital equipped to provide the required treatment.
- 5) Charges for transportation, including air transportation on a regular scheduled commercial flight from the hospital providing treatment to a hospital equipped to provide adequate treatment in a patient's city of residence, subject to written approval by the attending Physician and, if the total cost of transportation will exceed \$1000, the prior approval of the Trustees.

- 6) Charges of a hospital for services, medical supplies, co-insurance and short term stay facilities, ward accommodation and any additional charge for a private or semi-private room actually occupied if ward accommodation is not available or if required by a Physician, but not charges for the rental of telephones, televisions, radios or similar equipment.
- 7) Fees of Physician and charges for laboratory and x-ray services when ordered by a Physician
- 8) Charges for drugs available only by prescription when prescribed by a Physician but only in sufficient quantity to alleviate an acute medical condition.
- 9) Charges for local ambulance service to provide transportation to the nearest hospital equipped to provide the required treatment.
- 10) Charges for transportation, including air transportation on a regular scheduled commercial flight from the hospital providing treatment to a hospital equipped to provide adequate treatment in a patient's city of residence, subject to written approval by the attending Physician and, if the total cost of transportation will exceed \$1000, the prior approval of the Trustees.

**As noted above, this coverage is limited to a maximum period of absence from your Province of residence of 6 weeks. If you are outside your Province of residence for longer than 6 weeks it will be necessary for you to obtain additional coverage from a travel insurance provider.**

All out of Province claims are now facilitated through FrontierMEDEX, an international firm specializing in claims of this nature.

**Should you require emergency treatment while travelling please have your hospital or physician call FrontierMedex directly.**

**Toll free in North America 1-800-527-0218  
Worldwide 1-410-453-6330  
FrontierMEDEX PLAN Identification Number 347521**

## Exclusions and Limitations (EHB)

Expenses incurred for the following shall not be considered eligible expenses:

- 1) Expenses for benefits, care, services or supplies payable by or under the Medical Services Plan of B.C., the Hospital Program of B.C., Pharmacare, any Hospital Program, a Workers' Compensation Act, or any Government Authority.
- 2) Expenses eligible for reimbursement under any other group or individual plan.
- 3) Expenses for dental services of any kind including services as the result of automobile accidents in B.C. except as provided under the dental and extended benefit plans in this booklet.
- 4) Any portion of the fee of a Physician not allowable under the Basic Medical Plan except as provided under Eligible Expenses - Out of Province as outlined in this booklet.
- 5) Any portion of a fee or charge in excess of reasonable charges for the services performed.
- 6) Expenses incurred outside the Province of residence except as provided under Eligible Expenses - Out of Province as outlined in this booklet.
- 7) Expenses for services and supplies for cosmetic purposes or for the purpose other than the treatment of sickness or injury.
- 8) Expenses incurred in the treatment of any sickness or injury for which a person was hospitalized on the effective date of coverage.
- 9) Expenses incurred outside a person's province of residence due to therapeutic abortion or childbirth or for complications of pregnancy occurring within 2 months of the expected date of confinement.
- 10) Charges for contraceptive devices or sterilization procedures that are not covered under the Medical Services Act of B.C.
- 11) Charges of a Physician, Chiropractor, Naturopath, Physiotherapist, Massage Practitioner or Acupuncturist which are:

- For a medical examination required for the use of a third party.
  - For the completion of forms or reports for any purpose.
  - In excess of the schedule of fees allowed under the government medical plan in your province of residence, whether or not a participant in the Basic Medical Plan.
- 12) Charges for any brace, truss or other device prescribed primarily for protection against injury while participating in sports activities.
- 13) Charges for any services, supplies, drugs or other products determined by the Trustees not to be an eligible expense including drugs described as “lifestyle” drugs which include but are not limited to treatment for smoking cessation, weight loss, hair growth, erectile dysfunction, vaccines, vitamins, fertility treatment or for cosmetic purposes.
- 14) Expenses for repairs, maintenance, batteries, re-charging devices or other such accessories for hearing aids, wheel chairs, scooters or other durable equipment.
- 15) Expenses caused, contributed to or necessitated as the result of:
- War or any act of war or participation in a riot or civil insurrection.
  - Sickness or injury which was intentionally self-inflicted, whether sustained or suffered while sane or insane.
  - The commission by any eligible person of any unlawful act including an offence under the Criminal Code of Canada or a similar offence under the laws of any other country.
  - Injuries received due to the operation of a vehicle, if, when the injuries were received, the claimant’s blood contained more than eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.
- 16) Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.
- 17) Services or supplies not listed as covered expenses.

18) Services or supplies incurred during any period in which a person has been absent from his Province of residence in excess of 6 consecutive weeks.

19) Ambulance Service:

- Transportation arranged at the patient's convenience.
- Transportation arranged after waiting for Hospital accommodation for a condition not requiring immediate transportation to the Hospital.
- Transportation for the removal of a patient from one Hospital to another except in cases where the Hospital from which the patient is removed has inadequate facilities to provide the required treatment or as set out under the terms of the Plan.
- Transportation to a Hospital at which the patient is not admitted for emergency treatment.
- Charges for ambulance services where transportation does not actually occur shall be covered to a maximum of once in any 12 consecutive month period.

## DENTAL BENEFIT

This benefit is divided into three separate services:

### **Basic**

100% reimbursement of accepted fees for all eligible persons.

### **Major**

80% reimbursement of accepted fees for member, spouse and eligible dependent children over age 18, and 100% for dependent children under age 19.

### **Orthodontic**

50% reimbursement of accepted fees for all eligible persons.

## **Maximum Benefit**

- 1) The maximum benefit payable for any eligible person for **basic and major services combined** performed in any calendar year is \$3,000.
- 2) The maximum **lifetime benefit** payable for **orthodontic services** for any eligible person is \$3,000.

## **Pre-authorization**

If the treatment the dentist proposes exceeds \$500, involves the use of gold, crowns or bridgework, dentures or involves treatment to be provided by a specialist, a treatment plan should be submitted to the plan administrator for prior review. A Pre-authorization form will be sent to both you and your dentist confirming the amount that can be paid by your Plan.

## **Benefits**

Benefits are based on fee schedule amounts accepted by the Trustees.

The Plan covers most, but not all, of the procedures that are dentally necessary and are included in the general practitioners' fee guide. It is important to note this limitation as your dentist's charges (particularly if you are seeing a specialist) may be higher than those allowed by the Plan.

Fees greater than the benefit payable by the Plan or for ineligible services will be your responsibility.

## Benefits Payable

All eligible services will be payable based on fee schedules accepted by the Trustees for services performed by a Dentist, Denturist or Dental Hygienists.

## Co-ordination of Benefits

In the event that an eligible person is also entitled to benefits under any other insurance program or insurance policy, benefits will be co-ordinated with the other plan or insurer to ensure that the total benefit paid from all sources does not exceed 100% of the fee accepted by the Plan.

If your spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association. These guidelines are used by most, if not all, insurers in Canada.

We are the primary insurer for your expenses. Your spouse's insurer is the primary carrier for your spouse's expenses. Dependent children become the primary responsibility of the plan which insures the parent who has the earliest birth date in the year (month and day).

If the Plan is the secondary carrier, please remit copies of receipts paid by the primary carrier along with their statement of payment details.

## Eligible Services and Limitations

### Basic Services

- 1) **Diagnostic Services** - covered procedures necessary in the evaluation of a patient's level of oral health and the dental care required.
  - New Patient and Recall examinations shall be limited to a combined total of two per calendar year.
  - Specific examinations are limited to a combined total of two per calendar year.
  - Complete examinations are limited to once every 3 years and not within 6 months of a standard or new patient examination.
  - Accepted fees for x-rays shall be limited to an aggregate amount in any calendar year equivalent to the accepted fee for a full mouth series of x-rays.
  - Panoramic x-rays are limited to once in any 36 month period.

























































