UNITED FISHERMEN'S BENEFIT FUND

#4 - 830 14th Ave. Campbell River, B.C. V9W 4H4 778 645 0578 Benefits@ufawu.org

DENTAL PLAN SUMMARY January 2022

After the work has been done and you have paid the dentist you can claim your benefits. Please submit the **Standard Claim** form from your dentist for reimbursement. An amount of $50 (single) or $75 (family of two or more) will be deducted from your eligible expenses once each calendar year. You will then receive 70% of Part "A" and/or 40% of Part "B" for work done for beneficiaries, their spouses and dependent children to a maximum of $1,000 per family member per calendar year.

All Beneficiaries on the plan will be reimbursed at the same rate to a maximum of $1000 per family member per calendar year.

All dental claims must be submitted to the Benefit Fund office within 12 months of the date of dental service. Failure to meet that deadline will result in your claim being refused.

Your dentist is not required to obtain prior approval from the United Fishermen's Benefit Fund before rendering services. However, where the cost of service is other than a nominal charge, you may ask your dentist to submit a dental claim form showing the treatment that is planned and requesting a pre-authorization of the work. It is not necessary to include x-rays. This avoids any embarrassment between you and your dentist should you not be eligible for the proposed benefits. Pre-authorization for major work will inform you

- whether or not the proposed services are a benefit under your Plan and whether your yearly limitations have been reached.

PART A

The benefits under this section are those services that are required to maintain teeth in good order and normal restoration services to restore them in good order.

a) Diagnostic Services

All the necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental
treatment. This includes examinations, consultations and other diagnostic aids as may be deemed necessary.

b) Preventive Services

All necessary procedures to prevent the occurrence or oral diseases including:

i) Prophylaxis

ii) Topical fluoride applications

iii) Space maintainers — to maintain space, not to obtain more space.

c) Surgical Services

All necessary procedures for extractions and other surgical procedures normally performed by a general practicing dentist.

d) Endodontic Service (Root canals)

Treatment of disease of the pulp chamber and pulp canal.

e) Periodontic Services (Gums and bones)

Procedures necessary for the treatment of diseases of the soft tissue (gum) and the bones surrounding and supporting the teeth, but not tissue grafts.

f) Restorative Services

All necessary procedures for filling teeth with amalgam silicate (synthetic porcelain), acrylic (plastic) and composite resin restorations for restoring of tooth services which have been broken down as a result of decay process, including stainless steel crowns.

g) Prosthetic repair services and relines.

The Plan covers the repair of a fixed appliance and the repair or reline or removable appliances. Repair or reline of a removable appliance may be done by a dentist or licensed dental mechanic.

PART B - MAJOR SERVICES

a) Removable Prosthetics

1) Full upper and lower dentures. These may be provided by a dentist or a duly licensed dental mechanic.

2) Partial dentures: For coverage to be provided, these must be obtained from a dentist.

b) Crowns and Bridges

To artificially replace missing teeth with a fixed prosthesis.

c) Inlays and Onlays

Repair of badly broken-down teeth where other restorative material cannot be used satisfactorily.

d) Major Restorative Services

Inlays, onlays and gold foils will be covered only when other materials cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the difference in cost. In any event, a clinical explanation from your dentist is suggested

DUAL COVERAGE

Where the spouse or child of beneficiary has their own dental coverage through another plan, they must claim for dental benefits from their own plan first and the UFBF will reimburse as the second payer.

Receipts are required and the combined payment of both plans shall not exceed
100% of our fee guide.

SERVICES NOT COVERED

a) cosmetic dentistry, temporary dentistry, oral hygiene instruction, tissue grafts, drugs, and medicines.

b) charges for services commencing prior to date of coverage

c) implants for dentures and bridgework

d) orthodontic services

e) Claims not submitted to the Benefit Fund within the 12-month period following the date of dental service. Claims made for service performed more than a year ago will not be covered.

For more information, please contact:
Director: Christina Nelson
United Fishermen's Benefit Fund
Phone:778 645 0578 or 604-519-3644
Email: Benefits@ufawu.org

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CLAIM FOR DENTAL BENEFITS

MEMBER'S NAME ______ First ______ Initials ______ Last ______

ADDRESS ______________________ CITY ______________ PROV. ____

POSTAL CODE ________ DATE OF BIRTH ________ MM/DD/YYYY PHONE ______________

SOCIAL INSURANCE # ______________ PACIFIC BLUE CROSS # ______________

MEMBER: ❑ UFAWU-UNIFOR ❑ NBBC

STATUS: ❑ FISHER ❑ TENDERMAN ❑ RETIRED ❑ STAFF

DO YOU HAVE ANOTHER PLAN?
i.e. AANDC or, GREAT WEST LIFE etc.
❑ YES ❑ NO

NAME OF PLAN: ______________________

WHAT PERCENTAGE DOES IT PAY? ______________________

FISHING/PACKING YOU HAVE DONE IN THE PAST YEAR: (OR AT THE TIME OF RETIREMENT)

DATE (MO./YEAR)	TYPE OF FISHING	NAME OF BOAT	COMPANY YOU DELIVERED- MOST OF YOUR CATCH TO:

NAME OF PATIENT(S)	RELATIONSHIP (IF CHILD, AGE)	TOTAL	OFFICE USE ONLY			

DO YOU NEED MORE OF THESE FORMS SENT WITH YOUR PAYMENT? ❑ YES ❑ NO

PLEASE NOTE: STANDARD DENTAL CLAIM FORM from Dentist MUST BE INCLUDED, as well as

- RECEIPT or some other indication that dentist has been paid
- Allow 3 to 5 weeks for processing
- Claims MUST be submitted within 12 months of date of dental service

All information is true and complete. I consent to the disclosure of this personal information to UFBF, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

DATE ______________ MM/DD/YYYY SIGNATURE OF MEMBER ______________