(2) Medical Benefits for Retirees Beyond age 65

(i) A Health and Dental Spending Account ("Spending Account") shall be extended to those members who retire after December 31st 2009. The Spending Account will apply to members and eligible dependents.

(ii) The Spending Account will be available to members for the ten (10) years immediately following the member's 65th birthday or until death, whichever comes first.

(iii) Effective January 1st 2010, Retired Members are to receive a Spending Account to a maximum of twenty-five hundred dollars ($2,500.00) per annum and will cover eligible Health and Dental Benefits available to the members under the current Collective Agreement. Effective January 1st 2011, the Spending Account will be to a maximum of three thousand ($3,000.00) per annum.

(iv) All claims against the Spending Account will reflect the eligible maximums as outlined in the current Collective Agreement.

(v) All claims against the Spending Account must be accompanied by the original itemized statement and/or receipt from the medical service provider.

(vi) The Account survives for dependents until the date the member would have turned 75.

SCHEDULE "F"

SUMMARY OF BENEFITS

Charges in this Schedule qualify to the extent that they are reasonable, customary and medically necessary. This specifically includes, but not limited to, physiotherapy and drug benefits.

Clinical psychologist, Vision, Semi-Private and Dental benefits will not be subject to reasonable and customary limits as they have their own reasonable and customary amounts as set out herein.

EXTENDED HEALTH BENEFITS (EHB)

Deductible – Nil
100% reimbursement of eligible charges

Prescription Drugs

Deductible – Nil
100% reimbursement of eligible charges

Paramedical Services - maximum amounts allowed subject to the EHB Plan deductible and reimbursement percentage shown above.

a) Clinical Psychologist, Psychiatrist, Psychotherapist, or Social Worker:

The Employer shall pay for psychological services up to $200 for the first visit and up to $150 per subsequent visit to a maximum of $2,500 per year for each of the member, spouse and eligible dependents.

b) Registered Masseur:

Prescribed by a Physician
Maximum amount allowable: $600 per person per calendar year

c) Speech Pathologist:

Maximum amount allowable: $800 per person per calendar year

d) Osteopath, Chiropodist, Podiatrist:

Maximum amount allowable: $600 per person per calendar year

e) Chiropractic:

Maximum amount allowable: $600 per calendar year

f) Acupuncturist/naturopath

Maximum amount allowable: $600 per calendar year

Semi-Private Hospital Accommodation

Deductible – Nil
100% reimbursement of the charge made by a hospital for semi-private room accommodation, which is in excess of the standard ward rate.

Hearing Aids

Deductible – Nil
100% reimbursement up to a maximum of $1,000.00 per 36 consecutive months.

Vision

Deductible – Nil.

i) 100% reimbursement up to a maximum of $450.00 per 24 consecutive months. Effective January 1, 2020, increase to $500 per 24 consecutive months. Effective January 1, 2021, increase to $550 per 24 consecutive months.
ii) The cost of an eye exam, to a maximum of $75.00 every 24 months for each Member and Family. Effective January 1, 2021, increase to $95.00 per 24 months.
iii) The ability to apply vision care to the cost of laser eye surgery on a one time basis

When visual acuity can be improved to a least 20/40 with contact lenses and cannot be improved to that level with eyeglasses, this plan will pay up to a lifetime maximum of $200.00 for contact lenses when prescribed by a medical doctor, ophthalmologist or optometrist.

Out of Province Coverage

Deductible – Nil.
100% reimbursement of eligible charges.

EHB Overall Lifetime Maximum -

Unlimited **Dental Benefits**

Deductible – Nil

Dental Plan Procedures A-I

100% reimbursement of eligible charges, up to the amount specified in the applicable Fee Guide.

Dental Plan Procedures J-L

80% reimbursement of eligible charges, up to the amount specified in the applicable Fee Guide.

Dental Plan Procedure M (Orthodontic Services available for each Member, Spouse and Dependent)

Lifetime maximum of $3000.00 with 50/50 co-insurance

Dental Maximums:

Procedures A-I	-Unlimited
Procedures J-L	-$2,000 per person per 12 consecutive months
Procedure M	-Lifetime maximum of $3000 per Member, Spouse and dependent child

Fee Guide: Current Ontario Dental Association Fee Guide for General Practitioners.

PREDETERMINATION OF DENTAL BENEFITS

Prior to beginning a course of major dental treatment which is expected to cost $300 or more, you should obtain from your dentist and submit to Liberty Health a treatment plan outlining the procedures and charges. Your dentist may be requested to submit any relevant x-rays.

Approval of the treatment plan should be obtained from Liberty Mutual prior to commencement of treatment. After reviewing the plan, you will be advised of the amount payable by Liberty Mutual. Where a range of fees, individual consideration or laboratory charges are included, Liberty Mutual will determine the amount payable. The approved estimate will be honoured for a period of twelve months from the date of approval.

Note: A calendar year is January 1 to December 31.

Your group health and dental benefit plan is underwritten by Liberty Mutual Insurance Company. However, we conduct business under the name “Liberty Health”. Where statements of a contractual nature are included in this brochure, you will see the underwriter named. In all other cases, you will see references to Liberty Health.

ELIGIBLE DEPENDENTS

Dependents (if applicable) include:

i) your legally married spouse or a person of either sex with whom you have continuously cohabitated for a period of at least one (1) year in a common law relationship;

ii) Your natural or adopted child, stepchild, who is:
   a. unmarried
   b. under age 22, or under age 25 if a full-time student
   c. not employed on a full-time basis, and
   d. not eligible for coverage as an employee under this or any other Group

Coverage for an unmarried dependent child who is incapable of self support due to mental or physical disability shall continue beyond the limiting age stated above, provided satisfactory proof is given that the disability occurred while an eligible dependent:

a) within thirty days after attainment of the limiting age, and

b) as often as reasonably required thereafter.

A newborn child shall become eligible from the moment of birth.
It is the responsibility of the employee to notify the Benefits Section if your dependent no longer meets the definition of an eligible dependent.

CHANGES IN BENEFIT COVERAGE (Mandatory Positive Re-enrolment)

Changes in benefit coverage due to:

-marital status,
-name change,
-dependent coverage, or
-coordination of benefits
should be directed to the Human Resources Centre.

TERMINATION OF BENEFITS

Coverage for you and your dependents will cease on the earliest of:

- the date you terminate employment, retire or attain age 65;
- the date you cease to be eligible under the terms and conditions of the Group Agreement, or
- the termination date of the Group Agreement

EXTENSION OF BENEFITS

In the event of termination of employment while you or your dependent are totally disabled, benefits shall continue until the earliest of:

- the date the Group Agreement terminates;
- the date total disability ceases;
- the 90th day following termination of coverage; or
- the date you or your dependents become eligible for coverage under any other Group Policy.

CLAIMING BENEFITS

Assignment of Benefits to the Provider

In cases where your group benefit plan permits direct payments to providers, you may wish to assign benefits to the provider of the service (e.g. hospital, pharmacist, dentist, optician). If assignment is acceptable to the provider, present your Identification Certificate and the provider will bill Liberty Health directly. No claim forms are necessary.

Direct Claims Submission

Claims submitted directly to Liberty Health must include original receipts and a completed claim form including the following: your name and complete address; your group and identification numbers; group name; claimant's date of birth; dependent's name (if claim is on behalf of a dependent or spouse) plus relationship to you. Drug claims must indicate the prescription number, name, strength and quantity of the drug plus the drug identification number.

Claims should be submitted to: Liberty Health, Liberty Centre, 3500 Steeles Avenue East, Markham, Ontario L3R 0X4

Extended Health claims should be submitted within 180 days after the end of the calendar year in which the claim was incurred. If a delay is anticipated Liberty Health should be notified in advance. If the Group Agreement terminates, no payment is made with respect to any claims unless proof is submitted within 90 days of termination of the policy.

Dental claims should be submitted within 180 days after the end of the calendar year in which the claim was incurred. If a delay is anticipated Liberty Health should be notified in advance. If the Group Agreement terminates, no payment is made with respect to any claims unless proof is submitted within 90 days of termination of the policy.

COORDINATION OF BENEFITS

Your Liberty Health plan includes a Coordination of Benefits provision. If you have similar benefits through any other insurer, the amount payable through this plan shall be coordinated as follows, so that payment from all benefit plans does not exceed 100 percent of the eligible expenses. Where both spouses of a family have coverage through their employer benefit plans, the first payer of each spouse's claims is their own employer's plan. Any amount not paid by the first payer can then be submitted for consideration to the other spouse's benefit plan (the second payer).

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earliest birthday in a calendar year, and second to the other spouse's benefit plan. When submitting a claim to a second payer, be sure to include payment details provided by the first payer.

CONVERSION

When you or your dependent leave the group, application may be made for conversion to an individual plan. Application for conversion to an individual plan must be made within 60 days of leaving the group.

EXTENDED HEALTH BENEFITS

The benefits described below are available to you through Liberty Mutual Extended Health Benefit Plan when required as a result of sickness or accidental bodily injury.

Refer to the "Summary of Benefits" for information regarding reimbursement of this benefit.

GENERAL INFORMATION

No medical examination is required.
Benefits apply anywhere in the world. Reimbursement will be in Canadian funds up to the reasonable and customary charges for the services received, plus the rate of exchange if any, as determined by Liberty Mutual from the date of the last service provided.
Pre-existing conditions are covered from the moment the Agreement takes effect, except for dental care as a result of an accident.

BENEFITS

1. DRUGS - Formulary Two Mandatory Generic Plan: Drugs, serums, injectables and insulin (needles, syringes and test-tape for use by diabetics) purchased on the prescription of a medical doctor. Smoking cessation aids (transdermal patches and nicotine gum only) are limited to a 3 months supply per person per calendar year. Benefits are not payable for vitamins or vitamin preparations (unless injected), anti-obesity treatments, charges made for the administration of serums, vaccines or injectable drugs, and drugs not approved for legal sale to the general public in Canada.

The drug plan will be mandatory generic unless the physician instructs otherwise. However, there will be no detriment to the firefighters or their families by imposing the requirement that the least expensive form of the same drug be used.

2. PRIVATE NURSING: Charges for private nursing services which require, and can only be performed by a Registered Nurse (RN) or Registered Practical Nurse (RPN) when such services are provided in the home or hospital by a Nurse who is registered in the jurisdiction in which the services are performed and is not a relative of the patient, an employee of the hospital, nor lives in the home of the covered person. Nursing services must be certified medically necessary by the attending physician. Agency fees, commissions and overtime charges, or any amount in excess of the fee level set by the largest nursing registry in the province of Ontario, are not included.

An Authorization From for RN / RPN services must be completed by the attending physician and submitted to Manulife Financial. When the services are extended for more than 30 days, prior approval must be obtained from Manulife Financial on a monthly basis.

3. PHYSIOTHERAPY: Services of a licensed or registered physiotherapist who is not normally a resident in your home.

4. DIAGNOSTIC SERVICE: Diagnostic laboratory tests and x-rays performed in a hospital or licensed medical laboratory.

5. ACCIDENTAL DENTAL: Repair or replacement of natural teeth necessitated by a direct accidental blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident and treatment must occur while coverage is in force. Treatment must begin within 90 days of the accident, and must be

completed within three years. Liberty Health must be notified immediately. Payment will be made up to the fees set out in the Ontario Dental Association suggested Fee Guide for General Practitioners in effect on the date of treatment. The replacement of natural teeth is subject to a limit of $500 per accident.

6. PROSTHETIC APPLIANCES: Purchase of the following items when authorized in writing by the patient's attending physician: standard type artificial limb or eye, splints, trusses, casts, cervical collars, braces (excluding dental braces), catheters, urinary kits, external breast prostheses (following mastectomies), 2 pairs of surgical brassieres following a mastectomy, surgical stockings for relief and control of varicose veins or following surgery on the legs, wigs (following chemotherapy, to a maximum of $70), ostomy or colostomy supplies (where a surgical stoma exists), lancets, corrective prosthetic lenses and frames (once only for persons who lack an organic lens or after cataract surgery), custom-made boots or shoes or adjustments to stock item footwear, moulded arch supports (orthotics) up to maximum of $500 per calendar year.

7. DURABLE MEDICAL EQUIPMENT: Purchase or rental of the following items when authorized in writing by the attending physician: hospital bed, crutches, cane, walker, oxygen set, respirator (a device to provide artificial respiration), standard-type wheelchair and wheelchair repairs.

8. MEDICAL SERVICES AND SUPPLIES: Bandages or surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized in writing by the patient's attending physician.

9. AMBULANCE: Charges in excess of the provincial health plan allowance for licensed ambulance service or other emergency service used to transport the covered person from the place where bodily injury or disease is suffered to the nearest hospital where adequate treatment can be rendered, or from one hospital to another, or from hospital to the covered person's residence. (Emergency transportation includes transportation by air, rail or water.)

10. HOSPITAL EXPENSES AND SUPPLIES: Charges for hospital services and supplies obtained from a licensed hospital or surgical supply company while the person is not confined in the hospital.

11. PARAMEDICAL SERVICES: Services of the following licensed, certified or registered practitioners up to the maximums shown on the "Summary of Benefits" pages:

a) Clinical Psychologist;
b) Masseur – when the patient's attending physician authorizes in writing that such treatment is necessary;
c) Speech Pathologist – when the patient's attending physician or dentist authorizes in writing that such treatment is necessary;
d) Chiropractor, Osteopath, Podiatrist, Chiropodist.

12. VISION: Payment towards the purchase of new or replacement eyeglasses (frames and/or lenses) or contact lenses for you or an eligible dependent, when prescribed by your doctor, ophthalmologist or optometrist as a result of an eye examination. Charges to repair existing frames or lenses are also covered. Refer to your Summary of Benefits for the amount and frequency of payment. Eyeglasses must be purchased and repairs made for your use or the use of a recognized dependant. The certificate of coverage is not transferable.

Benefits are not payable for the cost of the eye examination is not covered (eye examinations however, may be covered under your basic provincial government health plan), industrial safety glasses, non-prescription sunglasses, charges for expenses covered by Worker's Compensation Board, or any government agency or third party.

13. HEARING AIDS: Payment towards the purchase of a hearing aid for you or an eligible dependent, when prescribed by a physician or hearing specialist. Eligible charges include the cost of repairs and initial batteries. Refer to your Summary of Benefits for the amount and frequency of payment.

Benefits are not payable for ear examinations, tests, replacement batteries or expenses covered by the Worker's Compensation Board or any government plan.

14. OUT OF PROVINCE COVERAGE: The following benefits provide protection when travelling (for other than health reasons) or vacationing outside your province of residence. Refer to the Summary of Benefits for information regarding reimbursement of this benefit.

a) Payment for the cost of hospital accommodation up to the ward level which is in excess of the amount paid by a provincial health plan or any other group plan.

b) Hospital services and supplies not normally provided in a) above.

c) Payment for charges made by a physician or surgeon (including diagnosis and treatment) when such charges are over and above the allowance made by provincial health plan.

d) Round trip economy air fare for a qualified medical attendant (not a relative) and the extra costs for the number of economy seats required to return the covered person, by most direct route, to the air terminal nearest the departure point in Canada, in the event that illness or injury is such that you must fly home and the attending physician or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant.

e) Payment for charges made by chiropractors, chiropodists and podiatrists to a maximum of $10 Canadian per treatment date, subject to payment by a provincial health plan.

Note: These benefits will not be paid for any condition resulting from a psychiatric disorder; or to patients in chronic care hospitals, chronic units of general hospitals, or nursing homes.

How to Claim Benefits

When eligible expenses are incurred outside your province of residence, request detailed receipts (in duplicate if possible). Send one set of receipts to your provincial government health plan for their consideration and payment. When they have replied, send original proof of their payment together with receipts and a completed claim form to Liberty Health for payment of remaining eligible benefits. Payment will be made in Canadian currency, based on the rate of exchange in effect at the conclusion of the service rendered as determined by any Canadian Chartered Bank. Please note that claims in foreign languages require an accompanying translation.

LIMITATIONS

Extended Health Benefits group coverage does not pay for:

Services normally paid through any provincial hospital plan, any provincial medical plan, Worker's Compensation Board, other government agencies or any other source.
Services provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, health spa, or when a patient is confined to a nursing home or home for the aged and receives Ontario government assistance.
Dental care (except as outlined under "Benefits").
Rest cures, travel for health reasons, insurance examinations or services or supplies for cosmetic purposes.
Any benefit provided outside Ontario at an amount greater than the reasonable and customary charges Liberty Mutual would pay for such a benefit, with t he exception of allowances for rates of exchange as outlined under "General Information".
Expenses incurred for benefits, or that part of benefits which cease to be payable under any government program.

SEMI-PRIVATE HOSPITAL ACCOMMODATION

Semi-Private Hospital Accommodation – if you are hospitalized in a public general or convalescent hospital or in a contracted private hospital in accordance with the formal agreement between the hospital and Liberty Mutual, payment will be made for room and board charges in excess of those payable by your provincial health plan, up to the difference in amount between the hospital standard ward charge and the semi-private room charge. When charges are incurred outside Ontario, Liberty Mutual will not pay amount which is greater than it would pay for such charges when provided in Ontario to a resident of Ontario.

Refer to your Summary of Benefits for information regarding reimbursement of this benefit.

DENTAL BENEFITS

Reimbursement of charges incurred by you and your eligible dependents for the following dental procedures will be made up to the fees outlined in the applicable Dental Association Fee Guide. Please refer to your Summary of Benefits for information regarding the appropriate Fee Guide and reimbursement of dental charges.

BENEFITS

A. Diagnostic

Examinations: 01101, 01102, 01103, 01202 (once every 9 months*), 01203, 01204, 01205

X-rays: 02102, 02102 (once every 24 months),
02111-02125, 02131-02136
02141-02146 (once every 9 months*)
02201-02204, 02209, 02304, 02401, 02402, 02409, 02411, 02412, 02419, 02504, 02509, 02601, 02701-02704, 02709, 02801, 02802, 02809, 02921, 02931-02934, 02939

Tests: 04101, 04201, 04311, 04312, 04321, 04322, 04401

Consultations: 05101-05104, 05109, 05201, 05202, 05209

B. PREVENTATIVE

Polishing: 11101, 11102, 11107, (one unit of time every 9 months*)

Scaling 11111-11117, 11119

Preventive Recall: 11201-11203, 11301-11303, 11401-11403, 11501-11503 (once every 9 months*)

Fluoride treatment: 12101

Oral hygiene instruction and reinstruction: 13211-13214, 13219, 13231, 13232, 13239 (once every 9 months*)

Space maintainers (applicable only to dependent children): 15101, 15103-15105, 15201, 15202, 15301, 15302, 15401, 15402, 15403, 15601, 15602, 15603, 15604

Occlusal equilibration: 43311-43314, 43319 (8 units of time every 12 months)

Pit and fissure sealants: 13401, 13409

*Once every 6 months for Dependent Children (as defined in the Eligible Dependents section of the Summary of Benefits).

C. MINOR RESTORATIVE

Caries/trauma/pain control: 20111, 20119, 20121, 20129

Amalgam restorations: 21111-21115, 21211-21215, 21221-21225

Retentive pins: 21401-21405

Stainless steel/plastic full coverage, preformed restorations (applicable only to dependent children under 12 years of age): 22201, 22211, 22301, 22311, 22401, 22411

Tooth coloured restorations: 23101-23105, 23111-23115, 23121, 23122, 23211-23215, 23221-23225, 23311-23315, 23321-23325, 23401-23405, 23411-23415, 23501-23505, 23511-23515

D. MINOR SURGICAL

Extractions: 71101, 71109, 71201, 71209, 72111, 72119, 72211, 72219, 72221, 72229, 72231, 72239

Removal of residual roots: 72311, 72319, 72321, 72329, 72331, 72339

E. ADDITIONAL SERVICES

Anaesthesia, used in conjunction with oral surgery, periodontal surgery, fractures and dislocations: 92101, 92102, 92212-92219, 92222-92229, 92301-92309, 92411-92419, 92431-92439, 92441

Professional visits: 94101, 94102, 94302

Consultation with a member of the profession: 93111, 93112, 93119

Drugs (injections): 96201, 96202

F. PERIODONTAL SERVICES

Non-surgical: 41101-41104, 41109, 41211-41214, 41219, 41301, 41302, 41309

Surgical: The maximum benefit payable will include charges for packing and post-surgical treatment. 42111, 42201, 42311, 42321, 42411, 42421, 42431, 42511, 42521, 42531, 42551, 42611, 42621, 42811, 42819, 42821-42823, 42829, 42831-42834, 42839, 73411, 73431

Adjunctive Services: 43111, 43211, 43231, 43241, 43261, 43281, 43289, 43421-43427, 43429, 43611, 43612, 43621-43623, 43629

G. ENDODONTIC SERVICES

Pulpotomy, Pulpectomy – primary teeth: 32231, 32231

Root canal therapy: 33111, 33115, 33121, 33125, 33131, 33135, 33141, 33145, 33401-33403

Apexification: 33601-33604

Re-insertion of dentogenic media: 33611-33614

Apicoectomy/Apical curettage: 34111, 34112, 34121-34123, 34131-34134, 34141, 34142, 34151-34153, 34161-34164

Retrofilling: 34211, 34212, 34221-34224, 34231-34234, 34241, 34242, 34251-34254, 34261- 34264

Root amputation: 34411, 34412

Surgery, endodontic, exploratory: 34441-34446

Perforations/resorptive defect, pulp chamber repair, or root repair, non-surgical, surgical: 34511, 34521-35423

Isolation of Endodontic Tooth/Teeth: 39101

Hemisection: 34421-34423

Endosseous implants; 34661, 34462, 34471

Chemical bleaching (endodontically treated tooth/teeth): 39311-39313, 39319

Intentional removal, apical filling & replantation: 34451-34453

Emergency procedures: 20131, 20139, 32221, 32222, 32311-32314, 32321, 32322, 39201, 39202, 39211, 39212

Replantation, avulsed tooth/teeth: 76941, 76949

Repositioning of traumatically displaced teeth: 76951, 76952, 76959

H. MAJOR SURGICAL

Gingival fiber incision: 42331, 42339

Surgical exposure of tooth: 72511, 72519, 72521, 72529, 72531, 72539

Transplantation of erupted tooth: 72611, 72619

Surgical repositioning of teeth: 72631, 72639

Enucleation of an unerupted tooth: 72711, 72719

Aleoloplasty: 73111, 73121

Excision, removal of bone: 73152-73154, 73161

Reduction of bone, tuberosity: 73171, 73172

Gingivoplasty and/or stomatoplasty: 73211, 73221-73223

Surgical excision (cysts and tumors): 74111-74118, 74631-74638

Surgical incision and drainage: 75112, 75121, 75301, 75302

Fractures: 76201-76204, 76301-76304, 76911-76913

Repair lacerations, uncomplicated: 76961-76963

Frenectomy: 77801-77803

Management o TMJ dislocation: 78102

Miscellaneous surgical services: 79111, 79311-79313, 79321, 79322, 79331-79333, 79341-79343, 79402-79404, 79601-79604

I. REMOVAL PROSTHODONTICS

Denture Adjustments (complete or partial dentures, after 3 months from insertion): 54201, 54202, 54209, 54301-54303, 54401-54403, 54501-54503

Denture repairs/additions: 55101, 55102, 55201-55203, 55301, 55302, 55401-55403, 55501, 55509,

Denture rebasing, relining: 56211-56213, 56221-56223, 56231-56233, 56241-56243, 56251-56253, 56261-56263, 56311-56313, 56321-56323, 56331-56333, 56341-56343, 56411-56413

Denture, tissue conditioning: 56511-56513, 56521-56523

Resetting of teeth: 56602

J. REMOVABLE PROSTHODONTICS – once every 5 years

Complete dentures: 51101-51104, 51301-51303, 51601-51603, 51701- 51703, 51801-51803

Partial dentures; 52101-52103, 52111-52113, 52201-52203, 5211-52213, 52301-52303, 52311-52313, 52401-52403, 52411-52413, 52501-52503, 52511-52513, 53101-53104, 53111-53113, 53201-52303, 53205, 53211-53213, 53215, 53301, 53302, 53304, 53401-53403, 53501-53503, 53611-53613, 53621-53623, 53701-53704, 53711-53713

K. FIXED PROSTHODONOTICS –once every 5 years

Pontics: 62101, 62103, 65201, 62502, 62701-62703

Repairs: 66111-66113, 66119, 66211-66213, 66219, 66301-66303, 66309, 66711, 66719, 66721, 66729

Retainers – crowns: 67101, 67102, 67121, 67129, 67131, 67139,67201, 67202, 67211, 67301, 67311

Retainers – inlay, onlay: 67321, 67322, 67331, 67341

Abutment preparation under existing partial denture clasp: 67501, 67502

Splinting: 69201

Retentive pins for retainers: 69301-69305

L. MAJOR RESTORATIVE

Metal inlay restorations: 25111-25113

Composite inlay restorations: 25121-25123

Metal onlay restoration: 25111

Composite onlay restoration: 25521

Retentive pins: 25601, 25602, 25603, 25604, 25605

Crowns: 27111, 27113, 27114, 27121, 27201, 27211, 27301, 27311

Post and core: 25711-25713, 25721-25723

Metal transfer coping: 27501, 27502

Natural tooth preparation: 28101

Metal cast coping crowns: 28211, 28212

Other restorative services: 21301, 23601, 25731-25733, 25741-25743, 25751-25756, 29101-29103, 29109, 29301-29303, 29309

M. ORTHODONTIC SERVICES – Applicable only to dependent children 18 years of age or under

Diagnostic services: 04931

Observation & adjustment: 80601, 80602, 80631, 80632, 80639, 80641, 80642, 80649, 80651, 80659, 80661, 80669

Removal of fixed orthodontic appliances: 80671, 80679

Orthodontic appliances: 81111, 81112, 81113, 81114, 81121, 81122, 81131, 81135, 81141, 81142, 81151, 81152, 81211, 81212, 81231, 81232, 81242, 81243, 81251, 81252, 81253, 81254, 81261, 81262, 81271, 81272, 81221, 81222, 81291-81294, 83101, 83102, 83201, 83202, 14101, 14102, 14201, 14202, 14301 14311, 14312, 14319, 14401-14403, 14409

Prior to commencement of orthodontic treatment, the dentist should prepare a report outlining the details with respect to malocclusion, diagnosis, proposed treatment and applicable fees. This treatment plan should be forwarded to Liberty Health for review to establish the extent of payable benefit.

In-office and commercial laboratory charges (when applicable to the above procedures): 99111, 99333

EXTENSION OF BENEFITS

If an employee or dependent has impressions taken or a tooth prepared for an appliance while covered and benefits cease because of termination of employment, then coverage will be deemed to continue in force for 90 days for charges incurred for that treatment.

Claims will not be paid for any crowns, bridges or dentures for which impressions were made prior to the date the person's coverage started. Also, claims will not be paid for replacement or mislaid, lost or stolen appliances.

EXCLUSIONS

Benefits are not payable for:

Services or supplies not listed under Benefits.
Services or supplies for cosmetic purposes, as determined by Liberty Mutual.
Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
Charges incurred as a result of self-inflicted injury.
Charges incurred while committing, or attempting to commit, directly or indirectly, a criminal act under legislation in the jurisdiction where the act was committed.
Charges for the completion of claim forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for transfer of medical files.
Charges for procedures in excess of those stated in the Fee Guide for General Practitioners.
Services or supplies paid through any other source such as government or any other service.
Services completed after termination of coverage.