



**Pensioners'
Dental
Services Plan
(PDSP)**

**Member
Booklet**

The PDSP is administered
by Sun Life Assurance Company
of Canada,
on behalf of the
Government of Canada

Contract Number 25555
Effective January 1, 2001

Printed in Canada
November 2000

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General Information

About this booklet

This Member Booklet summarizes the Pensioners' Dental Services Plan (PDSP) for convenience of reference, but does not substitute for the Plan. The complete terms and conditions of the plan are set out in the PDSP Rules. If there are any discrepancies or differences between this booklet and the PDSP Rules, the PDSP Rules will prevail.

To find out how to obtain the complete PDSP Rules, please refer to the "For More Information" section at the end of this booklet.

The booklet is divided into two main sections. The first part provides general information about the plan such as eligibility, how to enrol, how and when to make a claim. The second part of the booklet provides details about the benefits such as maximum reimbursement amounts and procedures covered.

The PDSP may be amended after the effective date of this booklet. You will receive written notification of changes to your plan. Please keep any future plan change notices with this booklet.

The Pensioners' Dental Services Plan (PDSP)

The PDSP is a voluntary dental services plan established by the Government of Canada to provide dental services coverage to eligible federal pensioners and their eligible family members, including survivors.

The PDSP is a "self-insured" plan. This means that all Plan expenses will be recovered from the contributions of the participating parties: the Plan Sponsor and plan members. The Government of

Canada has the sole legal and financial liability for the PDSP.

As Plan Sponsor, the Government of Canada pays 60% of the required contributions. Participating pensioner members pay the remaining 40% through monthly contributions.

Sun Life Assurance Company of Canada acts as Plan Administrator on behalf of the Government of Canada. The role of the Plan Administrator is to adjudicate claims according to both the PDSP Rules and Plan policy established by the Plan Sponsor.

Eligibility

You are eligible to apply for the PDSP if you are receiving a pension, annuity or annual allowance (including a survivor pension) under one of a number of federal superannuation acts. The eligibility criteria and a list of these Acts can be found in the PDSP Rules.

If you choose to enrol family members, they become eligible for coverage on the date you become eligible, or the date they first become an eligible family member, whichever is later.

You must enrol yourself if you wish to cover your family members.

You do not need to be living in Canada to either join the plan, or receive PDSP benefits.

Who qualifies as your family member

To be eligible, your family member must be your spouse, common-law partner, or unmarried child.

For the purposes of the PDSP, a “spouse” means the person to whom you are legally married. A “common-law partner” means the person with

whom you have been cohabitating in a conjugal relationship for a continuous period of at least one year.

If you have both a legal spouse and a common-law partner, you may cover only one of them under the plan. Divorced spouses cannot be covered.

For the purposes of the PDSP, a “child” means your unmarried child(ren) or the unmarried child(ren) of your spouse or common-law partner, including an adopted child, step-child and foster child.

To be eligible, a child must be:

- Under 21 years of age;
- Under 25 years of age and enrolled in an accredited school, college or university on a full-time basis; or
- 21 years of age or over and incapable of engaging in self-sustaining employment by reason of mental or physical impairment.

If a covered child becomes mentally or physically impaired, coverage will continue provided that:

- the child depends on you for support and maintenance; and
- the child remains unmarried.

In these cases, you should provide medical documentation concerning your child’s mental or physical impairment to the Plan Administrator within 31 days of the date the child reaches age 21, or age 25 if the child is a full-time student.

Enrolment

You must enrol to receive coverage. If you wish to cover any existing eligible family member you must also either enrol or defer coverage for that person at the time that you apply. To enrol, you must complete, sign and mail the PDSP Enrolment Form to Sun Life Assurance Company of Canada.

If both you and your spouse or common-law partner are eligible under this plan, you may both enrol for member coverage or one of you may be enrolled as the covered family member of the other. The same person cannot be enrolled as both a member and a covered family member. In addition, your eligible children can be covered by only one of you.

You can elect to defer coverage for your eligible children who are under the age of three at the time you enrol. However, you must request coverage for these children before the date they reach age 3.

When you enrolled in the PDSP you may have elected to defer coverage for an eligible family member because of coverage under another plan. When that other coverage ends you may enrol that person in the PDSP. To do so, you must complete, sign and mail the PDSP Enrolment Form to Sun Life Assurance Company of Canada within 60 days of the date the other coverage ends.

When coverage begins

Your coverage begins:

- on January 1, 2001 if you meet the eligibility requirements and enrol before January 1, 2001;
- on the effective date of your pension entitlement if you meet the eligibility requirements and enrol on or after January 1, 2001;

**Changes
affecting
your
coverage**

- the first day of the 2nd month following the date the Plan Administrator receives your completed PDSP Enrolment Form if you elected to defer coverage under this plan because you had comparable coverage under another dental plan and you are now enrolling for coverage due to the termination of such other coverage.

A family member's coverage begins:

- the date your coverage begins if you applied to cover an existing eligible family member at the same time that you enrolled in the PDSP; or
- the first day of the 2nd month following the date the Plan Administrator receives your completed PDSP Enrolment Form if you belong to the PDSP now and you apply to cover a new eligible family member.

Once you, your spouse or common-law partner become covered under the PDSP, you must remain covered for a period of at least 2 complete calendar years (e.g. if you become covered effective June 1, 2001 your calendar year commences January 1, 2002 and you cannot terminate your coverage before January 1, 2004).

From time to time, there may be circumstances that change your coverage needs.

Such circumstances would include:

- the death of a spouse, common-law partner or covered child;
- a divorce;
- a new marriage or common-law partnership;

- the birth or adoption of a child;
- a covered child reaching age 21 or age 25 if a full-time student.

To ensure that coverage is kept up-to-date, it is important that you report changes such as these to the Plan Administrator.

If you wish to cover a new eligible family member, you must complete, sign and mail the PDSP Enrolment Form to Sun Life Assurance Company of Canada within 60 days of the life event change.

Any resulting change in coverage will take effect on the first day of the 2nd month following the date the Plan Administrator receives your completed PDSP Enrolment Form.

If you wish to terminate coverage for yourself, your spouse or common-law partner after the required two calendar year period, you must advise the Plan Administrator in writing on the required form.

Please note that if you voluntarily terminate coverage, you cannot reinstate this coverage in the future.

When coverage ends

As a member, your coverage will end on the earliest of the following:

- the date you die;
- the first day of the 2nd month following the date the Plan Administrator receives your request to terminate coverage, provided you have been covered under the plan for at least 2 complete calendar years;

- the first day of the 2nd month following the month in which you cease to be an eligible pensioner; and
- the date the PDSP terminates, if ever.

In addition, if you provide the Plan Administrator with proof of other coverage under one of the plans specified below, your PDSP coverage will end on the date that you:

- become covered under the Dental Care Plan for the Public Service of Canada as an eligible employee;
- become entitled to dental services as a member of the Canadian Forces or the RCMP; or
- receive Veterans' Coverage.

A family member's coverage terminates on the earliest of the following:

- the date your coverage ends;
- the date your family member is no longer an eligible family member;
- the date your family member becomes covered as a member in his or her own right;
- the first day of the 2nd month following the date the Plan Administrator receives your request to terminate your spouse or common-law partner's coverage, provided your spouse or common-law partner has been covered under the plan for at least 2 complete calendar years.

In addition, if you provide the Plan Administrator with proof of other coverage under one of the following specified plans, your spouse's or common-law partner's coverage will end on the date that he or she:

**Payment of
monthly
contributions**

- becomes covered under the Dental Care Plan for the Public Service of Canada as an eligible employee;
- becomes entitled to dental services as a member of the Canadian Forces or the RCMP; or
- receives Veterans' Coverage.

Except for the first contributions, the monthly contribution amount, as well as any applicable tax, will be deducted from your pension each month to provide coverage for the following month.

After receiving your PDSP Enrolment Form, the Plan Administrator will advise your pension administration office to either begin or change the monthly contributions, as the case may be. For most new members, because monthly contributions are paid one month in advance, a double deduction will be made in the first few months following your coverage effective date. After this, regular monthly contributions will begin.

If your net pension is too small to cover the monthly contribution amount, you must pay your contributions directly to your pension administration office. That office will advise of the procedure to follow after you enrol.

**How and
when to
make a
claim for
benefits**

You may make a claim in several different ways.

Your dentist's office may have the capability to electronically submit your claim directly to Sun Life Assurance Company of Canada. This process, if available, provides faster and more efficient reimbursement of your claims without the need for you to submit a claim form.

You may also submit a claim by completing the PDSP claim form. After the Plan Administrator processes your first claim, you will receive a personalized claim form. You are encouraged to use the personalized claim form that we provide with each Explanation of Benefits. The personalized claim form contains pre-printed personal information, including your name and certificate number. It is convenient to use, and simplifies the processing of the next claim that you submit.

Your dentist's office may also have a similar standard claim form that we will accept.

Please mail your completed claim forms to the Plan Administrator at the following address:

Sun Life Assurance Company of Canada
Dental Claims Office
PO Box 9805 CSC-T
Ottawa ON K1G 6M6

Please note that you cannot submit a claim for any dental services received before January 1, 2001. These claims are not eligible for reimbursement under the PDSP.

In order for you to receive benefits, **the Plan Administrator must receive a claim no later than 15 months after the date you incur the expenses.**

Claims received after the 15 month period will not be paid unless it was impossible to submit the claim within that time. Further, except in the case of legal incapacity, no claim will be paid if it is submitted more than 24 months after the expense was incurred.

If dental services are received by a student during an academic break, claims in respect of that

**How to
contact the
Plan
Administrator**

service should not be submitted until the student has re-enrolled to study on a full-time basis.

We may require that you give us a statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

If you have any questions about your dental benefits, you may call Sun Life Assurance Company of Canada at 1-888-757-7427 (toll-free in North America), or 247-5100 in the National Capital Region. Customer Service Representatives are available from 7:00 a.m. to 8:00 p.m. (EST), Monday through Friday.

If you want information about the status of your claim, you may use *SunServe*, our interactive telephone system. *SunServe* is available at the following times:

- Monday to Friday 7:00 a.m. to 12:00 midnight (EST); or
- Saturday from 7:00 a.m. to 8:00 p.m. (EST)

If you have Internet access, you may also visit our web site at <http://www.sunlife.ca>.

For any inquiries related to the monthly contributions deducted from your pension, please contact your pension administration office directly.

**Coordination
of Benefits**

If you are also covered for health or dental benefits under another plan, the Plan Administrator will coordinate benefits with the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

- For dental services required as a result of an accidental injury to natural teeth covered under both the Public Service Health Care Plan and the PDSP, the benefits will be determined under the Public Service Health Care Plan first;
- For specific oral surgical procedures covered under both the Public Service Health Care Plan and the PDSP, the benefits will be determined under the PDSP first;
- If you are claiming expenses for your spouse or common-law partner, and that person is covered for those expenses under another plan, you must send the claim to your spouse or common-law partner's plan first;
- If you are claiming expenses for your children, and both you and your spouse or common-law partner have coverage for your children under different plans, you must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse or common-law partner's birthday is June 5, you must claim under the PDSP first;
- The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

The Plan Administrator can help you determine which plan you should claim from first.

Occasionally, you might not agree with how a claim was processed by the Plan Administrator or with the decision concerning the eligibility of either you or a family member under the PDSP. In this case, you should discuss and explore all options with the Plan Administrator. If this

Member complaints concerning claims or eligibility

**Recovering
overpayments**

discussion and exploration fails to provide a solution, you can request a review of the disputed claim or eligibility situation. If you wish to do this, send a submission to:

The Pensioners' Dental Services Plan
c/o Treasury Board of Canada Secretariat
Human Resources Branch
300 Laurier Avenue West, 5th Floor
Ottawa ON K1A 0R5

The Plan Administrator has the right, on behalf of the Plan Sponsor, to recover benefit overpayments.

**General
description
of the
coverage**

PDSP Benefits

In this section, *you* means the member and all family members covered under the PDSP.

The PDSP will reimburse plan members for eligible expenses that you incur for dental procedures performed by a dentist or dental specialist, or by a dental hygienist under the direct supervision of a dentist or dental specialist. The plan also reimburses the eligible services of a denturist, denturologist, dental mechanic, and an anaesthetist.

The dental practitioner must be licensed to provide services in the province or territory where the service was received.

If you reside in Canada, the plan will provide reimbursement up to the amounts specified in the following Dental Association Fee Guide for practitioners:

- for services received in Canada (except Alberta) – the Fee Guide in the province where the treatment is received that was in effect the previous year;
- for services received in the Province of Alberta – the 1997 Alberta Fee Guide, increased by an inflationary factor determined by the Plan Sponsor;
- for services received while temporarily outside of Canada – the above fee guide of the Province where the member lives.

If you reside permanently outside of Canada, the plan will provide reimbursement based on the

reasonable and customary charges in the locality where the eligible dental services were received.

For each dental procedure, the plan will reimburse reasonable and customary expenses.

If services are provided by a qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used.

You must submit a claim within 15 months from the date the expense was incurred. You incur an expense:

- on the date your single appointment procedure was performed;
- for other procedures that take more than one appointment, once the entire procedure is completed;
- for procedures that involve the installation of an appliance, on the date the appliance is installed. However, for orthodontic services, you are deemed to incur an expense monthly, beginning with the date the appliance is first installed.

Please note that you cannot submit a claim for any dental services received before January 1, 2001. These claims are not eligible for reimbursement under the PDSP.

Annual Deductible

The **annual deductible** is a specific dollar amount that you must satisfy each calendar year before you receive reimbursement by the plan.

The annual deductible amount is \$25 for one covered person, or \$50 for more than one covered person.

These amounts are subtracted from your first claim(s) during the year, and are indicated on your Explanation of Benefits (EoB) from the Plan Administrator.

After the deductible amount has been satisfied, claims will be paid up to the percentage of coverage allowed under this plan.

If all or part of the deductible is satisfied within the last 3 months of the year, your deductible for the next year will be reduced by this amount.

Co-payment amount

The plan will reimburse you for a percentage of the cost of the covered expenses you have incurred. This percentage is applied to the amount of expenses that exceeds the annual deductible amount. For example, the plan will reimburse you 50% of the costs of major restorative, major prosthodontic and major orthodontic services, and 90% for all other eligible services.

The remainder (i.e. 50% for major restorative and 10% for other eligible services) is the amount that you are required to pay toward each eligible expense. This is referred to as the **co-payment amount**.

Maximum reimbursement amount

In any calendar year the plan will reimburse an annual maximum amount of \$1,300 for each covered person. This excludes orthodontic services, which has a separate lifetime limit (see below).

If your coverage starts in the second half of the year, the maximum amount that the plan will reimburse for that year will be \$650.

Lifetime limit – orthodontic services

Orthodontic services are subject to a separate lifetime limit of \$2,500 for each covered person.

Treatment plan

We strongly recommend that you send us an estimate, before the work begins, for any major treatment or procedure that will cost more than \$300. You should send us a completed dental claim form that shows the treatment the dental practitioner is planning along with the associated cost. Both you and the dental practitioner will have to complete parts of the claim form. We will then tell you how much of the planned treatment is covered under the plan. This way you will know how much of the cost you will be responsible for before proceeding with the services.

The treatment plan is not valid if the treatment does not commence within 90 days of the date on which you submit it to us.

Preventive dental procedures

The PDSP covers procedures used to help prevent dental problems. They are procedures that a dental practitioner performs regularly to help maintain good dental health.

The plan will pay 90% of the eligible expenses for these procedures after you satisfy the annual deductible amount.

Oral examinations

Complete oral examination

One recall examination every 9 months

Emergency or specific examinations

Treatment planning

X-rays

One complete series of periapical x-rays every 36 months

Occlusal x-rays

One set of bitewing x-rays every 9 months

***Other
services***

Extra-oral x-rays

Sialography, use of dyes

One panoramic x-ray every 36 months

X-rays of single teeth, called periapical x-rays

Interpretation of radiographs from another source

Tomography

Required consultations

House calls, hospital calls and special office visits

Polishing (cleaning of teeth) and topical fluoride treatment once every 9 months

Emergency or palliative services

Diagnostic tests and laboratory examinations (biopsy of oral tissue and pulp vitality tests)

Provision of space maintainers for missing primary teeth

Pit and fissure sealants – only children under age 15 are covered for this treatment

Oral hygiene instruction, up to a maximum of 1 session every calendar year

Caries control

Enameloplasty

Basic dental procedures

The PDSP covers procedures used to treat basic dental problems. Some examples are filling cavities and extracting teeth.

The plan will pay 90% of the eligible expenses for these procedures after you satisfy the deductible.

Fillings

Amalgam, silicate, composite, acrylic or equivalent, including pin reinforcements required for these fillings. Replacement fillings for the same tooth and surface are covered only if the existing filling is at least 24 months old.

Endodontics

Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue, specifically:

- pulp capping;
- pulpotomy;
- periapical services; and
- other endodontic procedures.

Periodontics

Treatment of diseases of the gum and other supporting tissue, specifically:

- non surgical services;
- surgical services;
- post-surgical treatment;
- occlusal equilibration, limited to 8 time units in any 12 month period (one time unit = 15 minutes);
- scaling and root planing, limited to 6 time units every calendar year. In documented cases, with pre-approval of a Treatment Plan, this limit can be increased to 12 time units every calendar year (one time unit = 15 minutes); and
- other periodontic services.

Oral surgery

Surgery and related anaesthesia (other than transplants, and repositioning of the jaw), specifically:

- uncomplicated removal;
- surgical removal and tooth repositioning;
- alveoloplasty, gingivoplasty, stomatoplasty, osteoplasty and tuberoplasty;
- removal of excess mucosa;
- surgical excision;
- removal of cyst;
- surgical incision;
- removal of impacted teeth;
- repair of soft tissue;
- frenectomy and dislocations; and
- miscellaneous surgical services.

Repair

Repair or adjustment of dentures.

Rebase and reline

Rebasing and relining of an existing partial or complete denture, once every 36 months.

Miscellaneous

Drug injections.

Major dental procedures

The PDSP covers procedures used to treat major dental problems. Some examples are crowns, dentures or bridges.

The plan will pay 50% of the eligible expenses for these procedures after you satisfy the deductible.

Major restorations

Gold and porcelain inlays, gold foils, retention pins, posts and cores, crowns and other restorative services. Charges for a replacement crown are considered an eligible expense if the existing crown is **at least 5 years old** and cannot be made serviceable.

Repair

Repair of bridges.

Prosthodontics

Construction and insertion of bridges or standard dentures (temporary or permanent).

Charges for a replacement bridge or replacement standard denture are considered an eligible expense if:

- a natural tooth is extracted after the existing bridge or standard denture was initially inserted and the appliance could not be made serviceable. If the appliance could be made serviceable, only the portion of the cost related to the replacement of the extracted tooth will be considered an eligible expense;
- the existing bridge or standard denture is **at least 5 years old** and cannot be made serviceable;
- the existing bridge or standard denture was inserted temporarily, provided the replacement bridge or denture is inserted within 12 months of the temporary bridge or denture and the replacement appliance will be permanent;
- it is needed as the result of the insertion of an initial opposing denture after the date you became covered under this plan; and
- it is needed as the result of an accidental injury to a natural tooth that occurred after you became covered under this plan.

Orthodontic procedures

The following expenses are also included:

- exams, x-rays and diagnostic casts;
- retainers;
- abutments and retentive pins in abutments; and
- other prosthodontic services.

The PDSP covers procedures used to treat misaligned or crooked teeth up to a separate lifetime limit of \$2,500.

The plan will pay 50% of the following eligible expenses for these procedures, after you satisfy the annual deductible amount:

- fixed or removable appliances, such as braces;
- surgical services, observation and adjustments and repairs and alterations;
- retention appliances; and
- appliances to control harmful habits.

The plan will pay 90% of the following eligible expenses for these procedures, after you satisfy the annual deductible amount:

- orthodontic examinations;
- orthodontic x-rays; and
- orthodontic diagnostic casts.

Payments after coverage ends

If your coverage under the PDSP terminates, you will continue to be covered for 31 days following the date your coverage terminates, for the following procedures:

- endodontics, if the pulp chamber was opened before the date your coverage terminated;

What is not covered

- relining or rebasing of dentures, addition of a tooth to a removable denture and complete and partial dentures, when an impression was taken before the date your coverage terminated;
- gold inlays, crowns, and other restorative services, bridges, repairs to bridges, retainers, abutments and retentive pins for abutments, when a tooth is prepared before the date your coverage terminated; and
- orthodontic services for which you were entitled to a benefit prior to the date your coverage terminated.

The plan will not pay for services or supplies payable in whole or in part under any provincial, territorial or other public dental, hospital or health plan to which the person is eligible. This includes user fees and extra billing whether or not legislation allows private plans to cover the user fees and extra billing.

The plan will not pay for services or supplies that are not usually provided to treat a dental problem, including experimental treatments.

The plan will not pay for:

- procedures performed primarily to improve appearance including, but not limited to, porcelain or composite facings on crowns or bridges on molar teeth;
- the replacement of dental appliances that are lost, misplaced or stolen;
- charges for appointments that you do not keep;
- charges for completing claim forms;
- supplies usually intended for sport or home use, for example, mouthguards;

- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), and alteration or restoration of occlusion (building up and restoring the bite);
- dental treatment involving the use of precious metals, if such treatment could have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice, except for that portion of expenses which would have been incurred for treatment of a reasonable substitute;
- services or supplies which are, in whole or in part, the legal liability of another party;
- services or supplies for which there would be no charge in the absence of this coverage;
- services or supplies received outside of Canada by a person who resides in Canada, or to a child of a member who resides in Canada, which would be payable under a provincial health, dental or hospital plan if the services had been received in Canada;
- services or supplies related to the purchase, repair, modification or replacement of a duplicate prosthodontic appliance, for any reason;
- services received or supplies purchased before the date you became covered under this plan;
- charges for:
 - an appliance or a modification of one where an impression is made for such appliance or modification before you became covered under this plan,

- crowns, bridges and gold restorations for which a tooth was prepared before you became covered under this plan,
 - root canal therapy where the pulp chamber was opened before you became covered under this plan, and
 - orthodontic treatment, in respect of a member, spouse or common-law partner, where the initial appliance was installed before the person became covered under this plan;
- charges for a periodontal appliance, occlusal equilibration, and other related service as a result of a temporo-mandibular joint dysfunction (TMJ dysfunction); and
 - implants, except that a benefit may be paid based on the reasonable and customary charges for the least expensive alternative course of treatment that is an eligible dental service under the plan.

The PDSP does not reimburse dental work received by covered persons age 19 or over resulting from teeth malformed at birth or during development, which are not a Class I, II or III malocclusion.

The plan will not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Act or similar legislation.

Definitions

Here is a list of definitions of some terms that appear in this booklet. Other definitions appear in the various sections.

Dentist

A person licensed to practice dentistry by the appropriate governmental licensing authority, provided that such person renders a service within the scope of his or her license.

Fee Guide

A listing of charges established by dental associations for specified services provided by dentists in their province or territory.

Plan Administrator

Sun Life Assurance Company of Canada.

Plan

The Pensioners' Dental Services Plan (PDSP).

Reasonable and Customary amount

The amount that is usually charged to a person without coverage and does not exceed the general level of charges for the specific service in the locale where it was performed. The Plan Administrator determines these amounts by consulting the available fee guides of provincial or national practitioner associations.

We, our and us

We, our and us mean Sun Life Assurance Company of Canada.

For more information

About your PDSP benefits

Please contact the Plan Administrator, Sun Life Assurance Company of Canada, at 1-888-757-7427 (toll-free in North America), or 247-5100 in the National Capital Region. Customer Service Representatives are available from 7:00 a.m. to 8:00 p.m. (EST), Monday through Friday.

About your PDSP monthly contributions and pension deductions

Please contact your pension administration office.

***To obtain a
copy of the
PDSP Rules***

Please visit the Treasury Board of Canada Secretariat website at: www.tbs-sct.gc.ca

Printed copies of the PDSP Rules may be obtained by contacting the:

Distribution Centre
Treasury Board of Canada Secretariat
300 Laurier Avenue West
Ottawa ON K1A 0R5
Tel: (613) 995-2855 Fax: (613) 996-0518
Internet: Services-Publications@fin.gc.ca

TBS Distribution Centre Stock No.: TBS 006779